HJR 48 BRIEFING PAPER

MANDATES AND INSURANCE IN MONTANA

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Mandate Overview

Mandates may be either state-imposed or federally imposed. They may apply to either individual or group health benefit plans. Health insurers claim that mandates drive up the cost of coverage because they require certain benefits or services to be offered, regardless of whether they apply to all individuals. Advocacy groups contend that requiring upfront coverage of screenings and certain types of care will help to prevent more costly problems later on. Accordingly, lawmakers adopt some mandates as a public good, based on the assumption that requiring all insured people to receive a benefit will prevent a worse outcome and cost to society downstream. Other mandates may be in place because they have a vocal, effective constituency.

The issue for lawmakers is to determine whether a mandated benefit or service and the associated higher premium price potentially attached to it is worth the risk that some people will be unable to afford the higher price of premiums. Related to that issue is the question of whether legislators' regulation of the insurance market results in appropriate value for an insurance policy and protection of consumers. One key observation is that the policies under discussion here are not accident-only or disease-specific. The policies are general health insurance policies either written for the group or individual market.

The purpose of this paper is three-fold. One aspect is to look at who in Montana might be in the market for individual health insurance plans. The other is to provide information on mandates in Montana's insurance law as they apply to group and individual insurance, as part of the House Joint Resolution No. 48 study of health insurance reform. The paper uses a document provided by Blue Cross Blue Shield (see Appendix A), which was presented at a Senate Business, Labor, and Economic Affairs Committee on January 16, 2007. The document has been updated to include some changes from the 2007 session. The third piece of information addresses how individual policies differ from group policies.

Who is in the Market for Individual Insurance Health Plans?

Employment often is the critical factor for whether an individual has health insurance. Group insurance policies typically are the choice for employers, although the self-employed and small businesses may look at the market for individual health plans. These plans typically can be crafted to an individual's needs. The downside is that each policy premium then also reflects those needs. The greater the needs and the older the person being covered, the higher the premium.

Reports on health care coverage both nationally and in Montana have noted that employer provision of health insurance is decreasing. Nearly one-fifth of Montana's population (19%) experienced periods during a year without health insurance. In a 2004 report from the University of Montana Bureau of Business and Economic Research,

Steve Seninger found that 42.4% of businesses employing fewer than 10 people did not offer health insurance. Small businesses employing fewer than 10 people make up 18.1% of Montana's businesses. In contrast, employment in a company with 100 or more employees has a 92% chance of including health benefits for all employees. That figure is 78% for firms with 20 to 99 employees but only 34% for firms of less than 5 employees. See appendix to an HJR 48 Briefing Paper comparing Montana and Massachusetts statistics (under Nov. 7 meeting materials at the committee website: http://leg.mt.gov/css/committees/interim/2007_2008/econ_affairs/sub_com/default.asp). While determining the actual numbers of employed individuals eligible for group health insurance would be helpful, the issue at hand is to determine whether an individual health plan with few mandates might encourage more individuals -- whether self-employed, unemployed but able to afford coverage of some type[1], or employed in businesses that do not offer health insurance -- to obtain individual health insurance policies. Many of these workers are likely to be among the 29,204 workers in Montana who have independent contractor exemptions.[2]

What Mandates Exist in Montana Law?

Table 1 below reviews mandates in Montana statutes and provides a brief history. Where known, the information also lists whether the mandate is related to a federal mandate and whether the mandate is for group or individual policies. The table does not list all mandates. For example, the list of mandated providers is more extensive than that provided in the table. See the note to the table. Also, there is a requirement that adopted children be covered by insurance similar to how natural children are covered. Some items, such as contraceptives, were listed as mandates but were not detected in Montana insurance statutes, although that does not mean that they are not mandated elsewhere.

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[1] A National Institute for Health Care Management Report from April 2008 indicated that 7.3 million people at 400% of the federal poverty level did not have insurance. In this group were 1million children, 1.1 million parents and 5.2 million childless adults. See "Understanding the Uninsured: Tailoring policy solutions for different subpopulations", p. 1, Table 1, NIHCM Issue Brief.

[2] Based on a workers' compensation study by a consulting group for Montana's Department of Labor and Industry . See (http://erd.dli.mt.gov/sb270/iccommittee.ppt#393,9,Slide 9)

Table 1: Mandates* in Montana Law

**as indicated by a 2006 Blue Cross Blue Shield 2006 document that was distributed at a Senate Business, Labor, and Economic Affairs Committee meeting on January 16, 2007. The table includes updates from 2007 legislation.*

Mandate Type	Specifics	History
Health Coverage	Chemical Dependency	Title 33, chapter 22, part 7, addresses coverage for group health plans except that an applicability section, 33-22-704, does not indicate a difference between group and individual plans. 33-22-703, enacted in 1979, addresses coverage for mental illness, alcoholism, and drug addiction but specifies group plans.
	Convalescent Care	only required in 33-22-1521 but uniform health benefit plans for individuals to require benefits listed (33-22-245).
	Diabetes Education, Equipment, and Supplies	Applies to group health plans in 33-22-129. Enacted in 2001, HB 406. House Business & Labor 18-1; House 2nd reading 80-20. Senate Health: 8-1; Senate 2nd reading 44-2.
	Mammograms	33-22-132. Enacted 1991. Addresses group and individual. No federal statute.
	Mental Health, Mental Health Parity	Title 33, chapter 22, part 7, addresses coverage for group health plans except that an applicability section, 33-22-704, does not indicate a difference between group and individual plans.
	Severe Mental Illness	Parity between physical illness and severe mental illness (described as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder; and autism. 33-22-706, enacted 1999. SB 219, Senate Health: 11-0; Senate 2nd reading - 48-2; House Human Services 15-2; House 2nd reading 75-25. No federal law but parity legislation has passed both houses of Congress, apparently impacting only group plans.
	Maternity	A Montana Supreme Court decision [Bankers Life & Casualty Co. v. Peterson, 263 Mont. 156, 163, 866 P 2nd 241, 245 (1993)] found that an insurer that provides men with comprehensive coverage but does not cover pregnancy for women is in violation of the Montana Human Rights Act's unisex insurance statute, 49-2-309. An attorney general's opinion, Vol. 51, Op. 16, referenced that case and cited Title VII of the Civil Rights Act and Equal Employment Opportunity Commission rulings in concluding that an employer that offers prescription drug coverage must also offer contraceptive coverage.**

	Newborns: First 31 days	Under Newborns' and Mothers' Health Protection Act of 1996, newborns are to be covered for first 31 days if health plan offers maternity benefits. 33-22-133 references group and individual policies that provide maternity benefits. 33-22-504 references "a group disability policy or certificate of insurance", in requiring immediate accident and sickness coverage to person covered under the policy.
	PKU-Metabolic Disorders	Newborn screening. 33-22-131, required coverage for group and individual. Babies born in "facilities" to be screened under 50-19-203.
	Post-Mastectomy Care	Federal mandate under Women's Health and Cancer Rights Act of 1998. 33-22-134 is MT statute on postmastectomy care. Title 42 Sec. 300gg-52
	Contraception	An Attorney General Opinion (51 A.G. Op. 16, 2006) says that if an insurance policy covers prescription drug coverage, then the unisex insurance law (49-2-309) requires inclusion of coverage for prescription contraceptives and related medical services. The opinion cites Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-2(a)(1) as requiring an employer that offers employees comprehensive health plans to include prescription contraceptives.**
	Well-child care and immunizations	33-22-303, enacted 1991. Increased to age 7 by HB 687 in 2007. House Human Services: 13-1; House 2nd reading 72-28; Senate Public Health: 5-4; Senate 2nd reading 29-19.
Providers*** (broader than listed here. See note below)	Dental	33-22-111* freedom of choice of practitioners, including dentists, for group and individual insurance. Enacted 1967.
	Naturopathic Physicians	33-22-111 freedom of choice of practitioners. added naturopathic physicians in 1999.
	Advanced Practice Registered Nurses (Nurse Specialists)	33-22-111 freedom of choice of practitioners for group and individual insurance, covers advanced practice registered nurses. Nurse specialist added in 1983. Wording changed to advanced practice registered nurse in 1999.
	Physical Therapists	33-22-111 freedom of choice of practitioners for group and individual insurance. Added physical therapists in 2001.
	Physician Assistants	In both 33-22-111 and 33-22-114. Added to 33-22-111 in 1989 in same bill that enacted 33-22-114.
Process	Continuation of Coverage for Disabled Dependents	33-22-506 references "A group hospital or medical expense insurance policy or hospital or medical service plan contract..."

	Minimum Stay after Childbirth	Newborns' and Mothers' Health Protection Act of 1996 prohibits group providers that offer maternity benefits from restricting benefits related to a hospital stay for childbirth to less than 48 hours for vaginal delivery or 96 hours for cesarean.
	Pre-existing conditions -- look back period of 6 months	33-22-110 references 5 years, except for individual market, which is governed by 33-22-246 (and lists 3 years).
	Self-referral for OB-GYN	33-22-1904 states "A health benefit plan must permit self-referral to any participating obstetrician or gynecologist by a covered person.... for services covered under the health benefit plan." Enacted 1997. Definition includes individual or group plans.
	Cancer screening information	Enacted 2007. SB 387. 33-22-244(5) Requires individual policies to disclose written information on policy's cancer screening coverage. Votes: Senate Public Health - 6-0. Senate 3rd reading: 48-2. House Human Services: 9-5. House 2nd reading 73-27
	Creditable Coverage for groups over 50	Under Title 42 Section 300gg-41. Individuals with prior group creditable coverage cannot be denied coverage or enrollment or face preexisting condition exclusions unless no alternative state mechanism (like MCHA) is available, reserves are not adequate, or other exceptions.
	Coverage of dependents to age 25	Enacted 2007. SB 419. Requires policies to offer coverage of unmarried dependents to age 25. Votes: Senate Business & Labor 6-5; 2nd Reading Senate - 31-19; House Business & Labor 13-3; 2nd Reading House -72-28. For both group & individual policies. At option of covered employee. 33-22-201, governing format and content of individual policies allows coverage of "any children under a specified age that may not exceed 25 years..."

**Attorney General Mike McGrath in 51 A.G. Op. 16, 2006 noted that the Bankers Life court decision "specifically rejected the insurer's argument that covering pregnancy-related expenses would constitute reverse discrimination against men because men would be paying premiums for benefits only received by women. The Court noted that the policy at issue only contained a gender-specific exclusion related to pregnancy; no male gender specific exclusions were listed." The opinion also reviewed Title VII of the Civil Rights Act of 1964, rulings by the Equal Employment Opportunity Commission, and two district court rulings (Washington State and Nebraska) that said denial of contraceptive coverage was unlawful discrimination on the basis of sex.

***33-22-111 covers: "...any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, naturopathic physician, physical therapist, or advanced practice registered nurse as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of the person's practice. Whenever the policies or certificates insure against the expense of drugs, the insured has full freedom of choice in the selection of any licensed and registered pharmacist.

Differences between Individual and Group Coverage

Undoubtedly individual and group health insurance coverage have a range of differences not mentioned below. The list in Table 2 lists some of the key components of individual policies. Although group policies may be purchased and the content determined by the employer, an individual policy can be crafted, as mentioned earlier, to address an individual's needs. But the individual policy also has fewer federal protections. Where critical for a better understanding, the Table provides a "context for understanding".

Table 2: Provisions for Individual Coverage in Montana Statutes

Conditions	Statutory Basis	...Context for Understanding
Elimination Riders	33-22-109 Allows exclusion of coverage for specific 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..." Provisions related to preexisting conditions do not apply to elimination riders.	Subsection (2) says an insurer may not, except with agreement of the insured, apply retroactively. Enforcement of this provision is difficult because of 33-15-403 regarding misrepresentation in applications and 33-18-215, which prohibits postclaim underwriting unless there was a misrepresentation in the application. 33-22-205 gives 2 year time limit for using misstatement in application to void policy or deny a claim, except that fraudulent misstatements are exempt. This statute also allows up to 2 years from start of policy to reduce or deny claims on the basis of a disease or physical condition not excluded by name or specific description in the application.
Preexisting Conditions	33-22-246. Prohibits exclusion of coverage for preexisting conditions unless (a) medical advice, diagnosis, care, or treatment was recommended or received in the prior 3 years before the effective date of coverage AND (b) exclusion is not for more than 12 months. Exclusion is also disallowed for federally defined eligible individuals.	Insurer can waive that exclusion under 33-22-242 if person within 30 days of application for coverage had been covered under a qualified health plan for a "continuous" period. (No indication of what continuous means.)
Price changes based on age vs. other factors	33-22-243 says prices for individual policies can be changed based on age but factors other than age are to be "distributed proportionately" across all other policies sold to a defined set of individuals.	

Underwriting	Under Title 33, chapter 16, insurers cannot collaborate on underwriting. Credit scores can be used for some underwriting. Title 33, chapter 18, part 6.	Underwriting in the individual market allows an insurer to review a person's health status and claims history and decide whether or not to extend insurance or how to vary terms of coverage. As mentioned above, postclaim underwriting prohibits denial of a claim unless misrepresentation occurs.
Uniform health benefit plan	33-22-245 requires services and articles required in 33-22-1521(2) -- but does not require that each individual policy that is offered be a uniform health benefit plan.	A bill draft requested for the HJR 48 study, LC 7777, proposes a limited individual health benefit plan, using the Uniform Health Benefit Plan statute as a base.

To get an indication of how pricing for individual policies vary, based on age (one factor that can be used for pricing individual policies), see Blue Cross Blue Shield policies listed in Table 3. The Table also lists New West to indicate variations in deductibles, out-of-pocket maximums for individual and family policies. Most insurance companies have these variations, so not all are listed here.

Table 3: Sample Pricing and Options for Individual Policies* (2007 plans)

Blue Cross Blue Shield Montana https://bcbsmt.inshealth.com/ehi/Alliance?allid=Blu25493			
Blue Evolution PPO Indemnity Plan with $10,000 deductible, 40% coinsurance & 40% coinsurance after deductible:	HDHP Montana Option 1 Indemnity Plan with $2,500 deduction, 0% coinsurance and no charge for office visit after deductible:	Value Blue Indemnity with $5,000 deductible, 0% coinsurance and no charge for first $500 worth of office visits, then no charge after deductible met:	Health Montanan Option 5 Indemnity Plan with $2,500 deductible, 0% coinsurance and nothing for office visit after deductible:
For person born in 1986 living in Lewis & Clark County nonsmoker. Same for male and female			
$91.35/mo	**$131.52/mo**	**$151.45/mo**	**$262.01/mo.**
For person born in 1960, nonsmoker			
$160.68/mo	**$268.13/mo**	**$266.38/mo**	**$460.86/mo**
For woman born in 1970 living in Missoula, nonsmoker, with one child, aged 14			
Deductible is $10,000 for family	Deductible is $5,000 for family	Deductible is $5,000	Deductible is $2,500
$192.12/mo	**$215.29/mo**	**$318.51/mo**	**$551.04/mo**

New West Health Services http://www.newwesthealth.com/bizindividualaged2007.htm			
These policies do not list a price calculator on the website.			
New West Select (high deductible indemnity policy)	Premier West 2500	Valu-West $5000	Healthy Connections Indemnity
$7,500 deductible, which is waived for first $750 of eligible charges in office visits.	Individual deductible of $2,500 with 20% coinsurance, individual out of pocket maximum of $5,500. Not eligible for health savings account.	Individual deductible of $5,000 with 0% coinsurance, individual out of pocket maximum of $5,000. Eligible for health savings account	Deductibles from $500 to $5,000 ($10,000 for family). Coinsurance from 0% to 20% (with $500 deductible). Out of pocket maximums from $1,700 to $5,000 for individual and up to $10,000 for family.

*If provided by insurers at a later date, more insurance policies can be listed among the samples.

Appendix A : Available at: http://data.opi.mt.gov/legbills/2007/Minutes/Senate/Exhibits/bus10a05.pdf