HOUSE BILL NO. 349

INTRODUCED BY K. WILLIAMS

A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING INDIVIDUAL HEALTH INSURANCE DISCRIMINATION; PROVIDING EXCEPTIONS; REVISING PREEXISTING CONDITION HEALTH INSURANCE LAWS; AMENDING SECTIONS 33-22-109, 33-22-110, 33-22-157, AND 33-22-246, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Individual health insurance discrimination prohibited.** (1) A health insurance issuer offering individual health insurance coverage may not establish rules for eligibility, including continued eligibility, of any individual based on any of the following health status-related factors of the individual or a dependent of the individual:

(a) health status;

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

(c) claims experience;

(d) receipt of health care;

(e) medical history;

(f) genetic information;

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

(h) disability.

(2) An insurer offering individual health insurance coverage may not require an individual, as a condition of eligibility or continued eligibility, to pay a premium that is greater than the premium for a similarly situated individual on the basis of any health status-related factor in relation to the individual or a dependent of the individual.

(3) THIS SECTION DOES NOT APPLY TO EXCEPTED BENEFITS AS DEFINED IN 33-22-140.

Section 2. Section 33-22-109, MCA, is amended to read:

"33-22-109. Riders. (1) Except for group health insurance coverage provided by a group health plan

or a health insurance issuer or for individual disability insurance under [section 1], 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. 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) An insurer may not, except upon agreement by the insured, retroactively impose an elimination rider on an existing policy, certificate, or contract."

Section 3. Section 33-22-110, MCA, is amended to read:

"33-22-110. Preexisting conditions. (1) Except as provided in 33-22-246 ~~and~~, 33-22-514, and [section 1], 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 4. Section 33-22-157, MCA, is amended to read:

"33-22-157. Standards for review -- notice of deficiency. (1) (a) When reviewing a premium rate filing, the commissioner shall consider whether the proposed premium rate is excessive, inadequate, unjustified, or unfairly discriminatory. Rates may be considered excessive if they cause the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage. In order to determine if the rate is excessive, the commissioner shall consider whether:

(i) the assumptions on which the rate increase is based are reasonable; and

(ii) one or more of the assumptions is not supported by the evidence.

(b) Rates may be considered inadequate if the rate is unreasonably low for the coverage provided, and the commissioner may consider if the rate would endanger the solvency of the insurer or disrupt the insurance market in Montana.

(c) A rate increase may be considered unjustified if the health insurance issuer provides data or documentation in connection with the increase that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

(d) Rates may be considered unfairly discriminatory if they violate 33-18-206, [section 1], 33-22-526, 49-2-309, or other applicable state laws prohibiting discrimination in health insurance.

(2) In order to determine whether the proposed premium rates for health insurance coverage are not excessive, inadequate, unjustified, or unfairly discriminatory, the commissioner may consider:

(a) the health insurance issuer's financial position, including but not limited to surplus, reserves, and investment savings;

(b) historical and projected administrative costs and medical and hospital expenses, including medical trends;

(c) the historical and projected medical loss ratio;

(d) changes to covered benefits or health plan design, along with actuarial projections concerning cost savings or additional expenses related to those changes;

(e) changes in the health insurance issuer's health care cost containment and quality improvement efforts following the health insurance issuer's last rate filing for the same category of health plan;

(f) product development and startup costs, drug and other benefit costs or expenses, and product age and credibility;

(g) whether the proposed change in the premium rate is necessary to maintain the health insurance issuer's solvency or to maintain rate stability and prevent excessive rate increases in the future;

(h) historical and projected claims experience;

(i) trend projections related to utilization and service or unit cost;

(j) allocation of the overall rate increase to claims and nonclaims costs;

(k) allocation of current and projected premium for each enrollee each month;

(l) the 3-year history of rate increases for the product or group of products associated with the rate increase if the product is 3 years old or older and otherwise any available rate history;

(m) employee and executive compensation data from the health insurance issuer's annual financial statements; and

(n) any other applicable information identified in administrative rules adopted pursuant to Title 33, except that the administrative rules may not include by reference any provisions of Public Law 111-148 and Public Law 111-152 or any regulations promulgated under those laws.

(3) The commissioner shall review rate filings and, if applicable, shall provide a notice of deficiencies containing detailed reasons describing why the commissioner finds that the proposed premium rate is excessive, inadequate, unjustified, or unfairly discriminatory. The notice must be provided within 60 days of receipt of filing.

(4) Within 30 days after receiving a notice of deficiencies alleging that a proposed rate is excessive, inadequate, unjustified, or unfairly discriminatory, the insurer may amend its rate filing, request reconsideration based upon additional information, or implement the proposed rate, unless the rate is unfairly discriminatory, pursuant to subsection (1)(d).

(5) At the end of the 30-day period described in subsection (4), if the insurer implements a rate that the commissioner has determined to be excessive, inadequate, unjustified, or unfairly discriminatory, the commissioner shall publish the finding on the commissioner's website indicating the commissioner's determination."

Section 5. Section 33-22-246, MCA, is amended to read:

"33-22-246. Preexisting conditions relating to individual market. (1) Except as provided in [section 1] and subsection (2) of this section, a health insurance issuer offering 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."

NEW SECTION. **Section 6. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [section 1].

NEW SECTION. **Section 7. Effective date.** [This act] is effective on passage and approval.

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