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Legal Opinion 2011-009

TO: John Engen, Mayor; City Council; Bruce Bender, Chief Administrative Officer; Brentt Ramharter, Finance Director; Gail Verlanic, Human Resource Director

FROM: Jim Nugent, City Attorney

DATE May 23, 2011

RE: Mont. Code Ann. § 2-18-704(5) provides retirees shall pay full premium for continued group health insurance coverage

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FACTS:

City officials have inquired concerning continued participation by retired city employees in the City's health insurance plan as well as the payment of the health insurance premiums by retirees.

ISSUES:

(1) May a retired city employee continue to participate in the City's health insurance plan?

(2) With respect to the City's health insurance plan, what does Montana state law provide with respect to payment of a retiree's health insurance premiums?

CONCLUSIONS:

(1) Yes, retired city employees may continue to participate in the City's health insurance plan if they meet certain statutory criteria set forth in Mont. Code Ann. § 2-18-704(1) and (2).

(2) Mont. Code Ann. § 2-18-704 provides a person electing to remain a member of a Montana government employee health insurance program "shall pay the full premium for coverage and for that person's covered dependents."

LEGAL DISCUSSION:

Title 2, chapter 18, part 7 Montana Code Annotated, *Group Insurance Generally*, is applicable to Montana state and local government group health insurance programs for their employees and some eligible retirees and their dependents. An important statute for purposes

of this legal discussion is Mont. Code Ann. § 2-18-704, *Mandatory provisions*. Subsection (1) provides that the group health insurance plan must contain provisions allowing members of the plan who retire from active service under the appropriate retirement provisions to potentially remain a member of the plan.

Mont. Code Ann. § Section 2-18-704 provides in its entirety:

> **2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must contain provisions that permit:
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> (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, as amended, 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;
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> (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);
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> (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.
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> (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:
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> (a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);
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> (b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and
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> (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.
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> (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, 42 U.S.C. 1395, as amended, if the legislator:
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> (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, 42 U.S.C. 1395, as amended.

(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) An insurance contract or plan issued under this part must include substantially equivalent or greater coverage for outpatient self-management training and education for the treatment of diabetes and certain diabetic equipment and supplies as provided in 33-22-129.

(9) (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 (9)(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 immunization practice advisory committee of the U.S. department of health and human services.

(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 (9).

(d) For purposes of this subsection (9):

(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 subsection (9)(b) and delivered by a physician or a health care professional supervised by a physician.

(10) (a) Except as provided in subsection (10)(b), upon renewal, an insurance contract or plan issued under this part under which coverage of a dependent terminates at a specified age must, as provided in 33-22-152, continue to provide coverage for any unmarried dependent, as defined in 33-22-140(5)(b), until the dependent reaches 25 years of age or marries, whichever occurs first. For insurance contracts or plans issued under this part, the premium charged for the additional coverage of a dependent, as defined in 33-22-140(5)(b), may be required to be paid by the insured and not by the employer.

(b) An insurance contract or plan issued under this part for the state employee group insurance program and the university system group insurance program is not subject to subsection (10)(a).

(11) 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.

The criteria for eligibility for a retiree to continue as a member of the health insurance plan is set forth in Mont. Code Ann. § 2-18-704(1) and (2).

Also, it is important to note and emphasize Mont. Code Ann. § 2-18-704(5) specifically provides that a person electing to remain a member of a government group health insurance plan "**shall pay the full premium for coverage and that of the person's covered dependents."** (Emphasis added.)

CONCLUSIONS:

(1) Yes, retired city employees may continue to participate in the City's health insurance plan if they meet certain statutory criteria set forth in Mont. Code Ann. § 2-18-704(1) and (2).

(2) Mont. Code Ann. § 2-18-704 provides a person electing to remain a member of a Montana government employee health insurance program "shall pay the full premium for coverage and for that person's covered dependents."

OFFICE OF THE CITY ATTORNEY

/s/

Jim Nugent, City Attorney
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