**** Bill No. ****

Introduced By **********

By Request of the *********

A Bill for an Act entitled: "An Act providing for an individual limited health benefit plan; requiring reports; excluding plan from certain mandated insurance provisions; amending sections 33-22-111, 33-22-114, 33-22-131, 33-22-132, 33-22-134, 33-22-135, 33-22-201, 33-22-303, 33-22-304, 33-30-1003, 33-30-1013, 33-30-1014, 33-30-1016, 33-30-1017, 33-30-1018, 33-31-111, 33-31-301, 33-36-205, and 49-2-309, MCA; and providing an effective date and a termination date."

Be it enacted by the Legislature of the State of Montana:

NEW SECTION. **Section 1. Individual limited benefit plan -- reporting requirement.** (1) Each health insurance issuer delivering or issuing for delivery in this state a health benefit plan or managed care plan to an individual may offer an individual limited benefit plan that excludes mandated coverage requirements under Title 33 except for the following mandated coverage requirements:

(a) those provided in 33-22-133 through 33-22-135, which reflect federal mandates for individual health benefit plans under the Women's Health and Cancer Rights Act of 1998, 42 U.S.C. 300gg-6 through 300gg-52;

(b) coverage of newborns, as provided in 33-22-301, 33-30-

1001, or 33-31-301, as applicable; and

(c) severe mental illness as provided in 33-22-706.

(2) An individual limited benefit plan must include in bold, 10-point or greater type, a notice on the application and the outline of coverage required by 33-22-244 that the health benefit plan does not provide coverage of some or all of the mandates required of group or other individual policies or managed care plans under Title 33. The notice must disclose which mandates are not included.

(3) An individual limited benefit plan may exclude maternity coverage, notwithstanding 49-2-309, if no gender-specific coverage is included in the policy.

(4) (a) Each health insurance issuer shall report, by March 31 annually starting in 2010, to the commissioner the number of individual limited benefit plans that the health insurance issuer sold in the previous year.

(b) Based on the reports received under subsection (4)(a), the commissioner shall report to the economic affairs interim committee the number of individual limited benefit plans sold in the previous two-year period.

Section 2. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies and certificates to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) (a) ~~All~~ Except as provided in subsection (1)(b), all policies or certificates of disability insurance, including individual, group, and blanket policies or certificates, must

provide that the insured has full freedom of choice in the selection of 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.

(b) This section does not apply to an individual limited health benefit plan provided for in [section 1].

(2) This section may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1). This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

{*Internal References to 33-22-111:*
33-22-101x *33-30-102x*}

Section 3. Section 33-22-114, MCA, is amended to read:

"33-22-114. Coverage required for services provided by physician assistants. (1) ~~An~~ Except as provided in subsection (2), an insurer, a health service corporation, or any employee health and welfare fund that provides accident or health insurance benefits to residents of this state shall provide, in

group and individual insurance contracts, coverage for health services provided by a physician assistant as normally covered by contracts for services supplied by a physician if health care services that the physician assistant is approved to perform are covered by the contract.

(2) The provisions of subsection (1) do not apply to an individual limited health benefit plan provided for in [section 1]."

{*Internal References to 33-22-114: 33-22-101x*}

Section 4. Section 33-22-131, MCA, is amended to read:

"33-22-131. Coverage for treatment of inborn errors of metabolism. (1) (a) ~~Each~~ Except as provided in subsection (5), each group or individual medical expense disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

(2) Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods

used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

(3) For purposes of this section:

(a) "medical foods" means nutritional substances in any form that are:

(i) formulated to be consumed or administered enterally under supervision of a physician;

(ii) specifically processed or formulated to be distinct in one or more nutrients present in natural food;

(iii) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

(iv) essential to optimize growth, health, and metabolic homeostasis;

(b) "treatment" means licensed professional medical services under the supervision of a physician.

(4) These services are subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes durational limits, dollar limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(5) This section does not apply to <u>an individual limited health benefit plan provided for in [section 1] or</u> disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

{*Internal References to 33-22-131:*
2-18-704 x *33-22-101* x* *33-22-262x* *33-31-102x*
33-31-111a *33-31-111a* *33-35-306x*}

Section 5. Section 33-22-132, MCA, is amended to read:

"33-22-132. Coverage for mammography examinations. (1) ~~Each~~ Except as provided in subsection (4), each group or individual medical expense, cancer, and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) A minimum $70 payment or the actual charge if the charge is less than $70 must be made for each mammography examination performed before the application of the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establish durational limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to an individual limited

health benefit plan provided for in [section 1] or disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

{*Internal References to 33-22-132:*
33-22-101 x* *33-22-1827x* *33-31-102x* *53-6-101x*}

Section 6. Section 33-22-134, MCA, is amended to read:

"33-22-134. Postmastectomy care. ~~Each~~ (1) Except as provided in subsection (2), each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician and, in the case of a health maintenance organization, also the primary care physician, in consultation with the patient, to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer. This section also applies to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, county, school district, or other political subdivision of the state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974.

(2) An individual limited health benefit plan provided for in [section 1] may exclude the coverage in subsection (1) that is not mandated by the Women's Health and Cancer Rights Act of 1998, 42 U.S.C. 300gg-6 through 300gg-52."

{*Internal References to 33-22-134:*
33-22-101 x* *33-31-111a* *33-31-111 a* *33-35-306x*}

Section 7. Section 33-22-135, MCA, is amended to read:

"33-22-135. Coverage for reconstructive breast surgery after mastectomy. (1) ~~Each~~ Except as provided in subsection (2), each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for:

(a) reconstructive breast surgery resulting from a mastectomy that resulted from breast cancer~~.~~

~~(2) Each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for~~; and

(b) all stages of one reconstructive breast surgery on the nondiseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed.

(2) An individual limited health benefit plan provided for in [section 1] may exclude the coverage in subsection (1) that is not mandated by the Women's Health and Cancer Rights Act of 1998, 42 U.S.C. 300gg-6 through 300gg-52.

(3) For the purposes of this section:

(a) "mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer;

(b) "reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(4) Benefits for reconstructive breast surgery include but are not limited to the costs of prostheses and, under any contract providing outpatient x-ray or radiation therapy, benefits for outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer that must be included as a part of the outpatient x-ray or radiation therapy benefit."

{*Internal References to 33-22-135:*
33-22-101 x* *33-31-111a* *33-31-111 a* *33-35-306x*}

Section 8. Section 33-22-201, MCA, is amended to read:

"33-22-201. Format and content. An individual policy of disability insurance may not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code and complies with the following:

(1) The entire money and other considerations for the policy must be expressed in the policy.

(2) The time when the insurance takes effect and terminates must be expressed in the policy.

(3) The policy may insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is the policyholder, any two or more eligible members of that family,

including husband, wife, dependent children or any children under a specified age that may not exceed 25 years, and any other person dependent upon the policyholder.

(4) (a) ~~The~~ Except as provided in subsection (4)(b), the style, arrangement, and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in lightfaced type of a style in general use, the size of which must be uniform and not less than 10 point with a lowercase, unspaced alphabet length not less than 120 point.

(b) The notice required in [section 1] must be printed as specified in [section 1] and must be distinguishable from the remainder of the policy.

(5) The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in 33-22-204 through 33-22-215 and 33-22-221 through 33-22-231, must be printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) The policy may not contain a provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks or short-rate table filed with the commissioner."

{*Internal References to 33-22-201: None.*}

Section 9. Section 33-22-303, MCA, is amended to read:

"33-22-303. Coverage for well-child care. (1) (a) ~~Each~~ Except as provided in subsection (4), each medical expense policy of disability insurance or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber 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 policy or certificate issued under the policy.

(2) Coverage for well-child care under subsection (1)(a) must include:

(a) 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

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to an individual limited health benefit plan as provided in [section 1], or disability income, specified disease, accident-only, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

{*Internal References to 33-22-303:*
33-31-301a *33-31-301a*}

Section 10. Section 33-22-304, MCA, is amended to read:

"33-22-304. Continuation of coverage for individuals with disabilities -- individual contracts. (1) ~~An~~ Except as provided in subsection (3), an individual hospital or medical expense insurance policy or hospital or medical service plan contract delivered or issued for delivery in this state that provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy or contract must also provide in substance that attainment of the limiting age may not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical disability and chiefly dependent upon the policyholder or subscriber for support and maintenance. Proof of retardation or the disability and dependency must be furnished to the insurer or hospital or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation. Proof may not be required more frequently than annually after the 2-year period following the child's attainment of the limiting age.

(2) Notwithstanding any other exemption or contrary law, the provisions of this section have equal application to hospital or medical expense insurance policies and hospital and medical service plan contracts.

(3) This section does not apply to an individual limited health benefit plan provided for in [section 1]."

{*Internal References to 33-22-304:*

33-6-101x 33-22-101x}

Section 11. Section 33-30-1003, MCA, is amended to read:

"33-30-1003. Continuation of coverage for persons with disabilities -- individual contracts. (1) (a) ~~An~~ Except as provided in subsection (1)(b), an individual hospital or medical service plan contract delivered or issued for delivery in this state that provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the contract must also provide in substance that attainment of the limiting age may not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical disability and chiefly dependent upon the subscriber for support and maintenance. Proof of retardation or the disability and dependency must be furnished to the hospital or medical service plan corporation by the subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the corporation. Proof may not be required more frequently than annually after the 2-year period following the child's attainment of the limiting age.

(b) Subsection (1)(a) does not apply to an individual limited health benefit plan provided for in [section 1].

(2) Notwithstanding any other exemption or contrary law, the provisions of this section have equal application to hospital or medical expense insurance policies and hospital and medical service plan contracts."

{*Internal References to 33-30-1003:*
33-22-140 x 33-22-1803x}

Section 12. Section 33-30-1013, MCA, is amended to read:

"33-30-1013. Coverage required for services provided by nurse specialists. ~~A~~ (1) Except as provided in subsection (2), a health service corporation shall provide, in group and individual insurance contracts, coverage for health services provided by a nurse specialist, as specifically listed in 37-8-202, if health care services that nurse specialists are licensed to perform are covered by the contract.

(2) Subsection (1) does not apply to an individual limited health benefit plan provided for in [section 1]."

{*Internal References to 33-30-1013: None.*}

Section 13. Section 33-30-1014, MCA, is amended to read:

"33-30-1014. Coverage for well-child care. (1) (a) ~~Each~~ Except as provided in subsection (1)(b), each disability insurance plan or group disability insurance plan that is delivered, issued for delivery, renewed, extended, or modified in this state by a health service corporation and that provides coverage for a family member of the insured or subscriber 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 plan.

(b) Subsection (1)(a) does not apply to an individual

limited health benefit plan provided for in [section 1].

(2) Coverage for well-child care under subsection (1)(a) must include:

(a) 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

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered at the intervals required in that subsection by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a disability insurance plan or group disability insurance plan issued by a health service corporation provides

coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the health service corporation that issued or delivered the policy or certificate is located inside or outside of this state."

{*Internal References to 33-30-1014: None.*}

Section 14. Section 33-30-1016, MCA, is amended to read:

"33-30-1016. Coverage for adopted children from time of placement -- preexisting conditions. (1) (a) ~~Each~~ Except as provided in subsection (1)(b), each individual or group membership contract issued or amended by a health service corporation in this state that provides coverage of dependent children of a member must provide coverage for an adopted child of the member to the same extent as for natural children of the member.

(b) Subsection (1)(a) does not apply to an individual limited health benefit plan provided for in [section 1].

(2) The coverage required by this section must be effective from the date of placement for the purpose of adoption and must continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage at the time of placement must include the necessary care and treatment of medical conditions existing prior to the date of placement.

(3) As used in this section, "placement" has the meaning as defined in 33-22-130."

{*Internal References to 33-30-1016: None.*}

Section 15. Section 33-30-1017, MCA, is amended to read:

"33-30-1017. Coverage required for services provided by naturopathic physicians. (1) ~~A~~ Except as provided in subsection (2), a health service corporation shall provide, in group and individual insurance contracts or certificates, coverage for health services provided by a naturopathic physician licensed pursuant to Title 37, chapter 26, if the health care services that naturopathic physicians are licensed to perform are covered by the contract or certificate.

(2) Subsection (1) does not apply to an individual limited health benefit plan provided for in [section 1]."

{*Internal References to 33-30-1017: 33-22-262x*}

Section 16. Section 33-30-1018, MCA, is amended to read:

"33-30-1018. Coverage required for services provided by physical therapist. (1) ~~A~~ Except as provided in subsection (2), a health service corporation shall provide, in group and individual insurance contracts or certificates, coverage for health services provided by a physical therapist licensed pursuant to Title 37, chapter 11, if the health care services that physical therapists are licensed to perform are covered by the contracts or certificates.

(2) Subsection (1) does not apply to an individual limited health benefit plan provided for in [section 1]."

{*Internal References to 33-30-1018: None.*}

Section 17. Section 33-31-111, MCA, is amended to read:

"33-31-111. (Temporary) Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of

33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36, except as provided in 33-22-262; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Except as provided in 33-22-262 and [section 1], the provisions of Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-152, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-31-111. (Effective July 1, 2009) Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance

organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Except as provided in [section 1], Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-152, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations."

{*Internal References to 33-31-111: None.*}

Section 18. Section 33-31-301, MCA, is amended to read:

"33-31-301. (Temporary) Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with 33-1-501.

(3) An evidence of coverage issued or delivered to a person residing in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) except as provided in 33-22-262, a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) <u>except as provided in [section 1],</u> a provision

providing coverage as required in 33-22-133;

(g) except as provided in 33-22-262 and [section 1], a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(h) except as provided in [section 1] a provision requiring

coverage for well-child care for children from the moment of birth through at least 7 years of age that is exempt from any deductibles and that includes:

(i) a history, a physical examination, developmental assessment and anticipatory guidance, as those terms are defined in 33-22-303, 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 recommended by the immunization practices advisory committee of the U.S. department of health and human services;

(i) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

(j) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(k) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner in accordance with 33-1-501 and issued to the enrollee.

(5) (a) Except as provided in 33-22-262, a health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) Except as provided in 33-22-262, a health maintenance organization may not issue or amend an evidence of coverage in

this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) The provisions of 33-1-501 govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(8) Prior to issuance of an evidence of coverage, written informational materials describing the contract's cancer screening coverages must be provided to a prospective applicant. The informational materials are not subject to filing with and approval of the insurance commissioner. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-31-301. (Effective July 1, 2009) Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of

coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with 33-1-501.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee

is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other

charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) except as provided in [section 1], a provision providing coverage as required in 33-22-133;

(g) except as provided in [section 1], a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit

treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(h) except as provided in [section 1], a provision requiring coverage for well-child care for children from the moment of birth through at least 7 years of age, including:

(i) a history, a physical examination, developmental assessment and anticipatory guidance, as those terms are defined in 33-22-303, 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 recommended by the immunization practices advisory committee of the U.S. department of health and human services;

(i) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

(j) a provision that the health maintenance organization

shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(k) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner in accordance with 33-1-501 and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e),

as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) The provisions of 33-1-501 govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(8) Prior to issuance of evidence of coverage, written

informational materials describing the contract's cancer screening coverages must be provided to a potential applicant. The informational materials are not subject to filing with and approval of the insurance commissioner."

{*Internal References to 33-31-301:*
33-22-262 x *33-22-262x* *33-31-102x* *33-31-201x*
33-31-304x *33-31-402x*}

Section 19. Section 33-36-205, MCA, is amended to read:

"33-36-205. (Temporary) Emergency services -- exception. (1) ~~A~~ Except as provided in subsection (6), a health carrier offering a managed care plan shall provide or pay for emergency services screening and emergency services and may not require prior authorization for either of those services. If an emergency services screening determines that emergency services or emergency services of a particular type are unnecessary for a covered person, emergency services or emergency services of the type determined unnecessary by the screening need not be covered by the health carrier unless otherwise covered under the health benefit plan. However, if screening determines that emergency services or emergency services of a particular type are necessary, those services must be covered by the health carrier. A health carrier shall cover emergency services if the health carrier, acting through a participating provider or other authorized representative, has authorized the provision of emergency services.

(2) A health carrier shall provide or pay for emergency services obtained from a nonnetwork provider within the service

area of a managed care plan and may not require prior authorization of those services if use of a participating provider would result in a delay that would worsen the medical condition of the covered person or if a provision of federal, state, or local law requires the use of a specific provider.

(3) If a participating provider or other authorized representative of a health carrier authorizes emergency services, the health carrier may not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item or health care services furnished in reliance on approval unless the approval was based on a material misrepresentation about the covered person's medical condition made by the provider of emergency services.

(4) Coverage of emergency services is subject to applicable coinsurance, copayments, and deductibles.

(5) For postevaluation or poststabilization services required immediately after receipt of emergency services, a health carrier shall provide access to an authorized representative 24 hours a day, 7 days a week, to facilitate review.

(6) (a) The provisions of this section do not apply to a limited coverage individual managed care plan as provided in 33-22-261 through 33-22-263.

(b) An individual limited health benefit plan may exclude provision for emergency services, but if an individual limited health benefit plan offers emergency services benefits, the remainder of this section applies. (Terminates June 30,

2009--sec. 14, Ch. 325, L. 2003.)

33-36-205. (Effective July 1, 2009) Emergency services. (1) ~~A~~ Except as provided in subsection (6), a health carrier offering a managed care plan shall provide or pay for emergency services screening and emergency services and may not require prior authorization for either of those services. If an emergency services screening determines that emergency services or emergency services of a particular type are unnecessary for a covered person, emergency services or emergency services of the type determined unnecessary by the screening need not be covered by the health carrier unless otherwise covered under the health benefit plan. However, if screening determines that emergency services or emergency services of a particular type are necessary, those services must be covered by the health carrier. A health carrier shall cover emergency services if the health carrier, acting through a participating provider or other authorized representative, has authorized the provision of emergency services.

(2) A health carrier shall provide or pay for emergency services obtained from a nonnetwork provider within the service area of a managed care plan and may not require prior authorization of those services if use of a participating provider would result in a delay that would worsen the medical condition of the covered person or if a provision of federal, state, or local law requires the use of a specific provider.

(3) If a participating provider or other authorized representative of a health carrier authorizes emergency services,

the health carrier may not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item or health care services furnished in reliance on approval unless the approval was based on a material misrepresentation about the covered person's medical condition made by the provider of emergency services.

(4) Coverage of emergency services is subject to applicable coinsurance, copayments, and deductibles.

(5) For postevaluation or poststabilization services required immediately after receipt of emergency services, a health carrier shall provide access to an authorized representative 24 hours a day, 7 days a week, to facilitate review.

(6) An individual limited health benefit plan may exclude provision for emergency services, but if an individual limited health benefit plan offers emergency services benefits, the remainder of this section applies."

{*Internal References to 33-36-205: 33-22-262x*}

Section 20. Section 49-2-309, MCA, is amended to read:

"49-2-309. Discrimination in insurance and retirement plans. (1) It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including

discrimination in regard to rates or premiums and payments or benefits.

(2) This section does not apply to any insurance policy, plan, or coverage or to any pension or retirement plan, program, or coverage in effect prior to October 1, 1985.

(3) It is not a violation of the prohibition against marital status discrimination in this section for an employer to provide greater or additional contributions to a bona fide group insurance plan for employees with dependents than to those employees without dependents or with fewer dependents.

(4) It is not a violation of the prohibition against discrimination on the basis of sex to exclude maternity benefits for the purposes of an individual limited health benefit plan, provided for in [section 1], if the individual limited health benefit plan does not offer any gender-specific benefits."

{*Internal References to 49-2-309:*
33-1-502x *33-22-262x*}

NEW SECTION. **Section 21. {standard} 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 22. {standard} Effective date.** [This act] is effective July 1, 2009.

NEW SECTION. **Section 23. {standard} Termination.** [This

act] terminates June 30, 2016.

- END -

{Name : Pat Murdo
Title : Legislative Research Analyst
Agency: Legislative Services Division
Phone : 444-3594
E-Mail: pmurdo@mt.gov}