AN ACT REVISING THE MENTAL HEALTH PARITY ACT TO INCLUDE COVERAGE OF SERVICES PROVIDED THROUGH THE PSYCHIATRIC COLLABORATIVE CARE MODEL OR PRIMARY CARE BEHAVIORAL HEALTH MODEL; REQUIRING MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND PUBLIC EMPLOYEE BENEFIT PLANS TO COMPLY WITH THE REQUIREMENTS OF THE MENTAL HEALTH PARITY ACT; AMENDING SECTIONS 2-18-704, 33-22-702, 33-22-705, AND 33-35-306, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE.

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

Section 1. Section 2-18-704, MCA, is amended to read:

"**2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must contain provisions that permit:

(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, 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;

(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);

(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.

(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:

(a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);

(b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and

(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.

(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 if the legislator:

(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.

(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:

(a) treatment of inborn errors of metabolism, as provided for in 33-22-131; ~~and~~

(b) therapies for Down syndrome, as provided in 33-22-139; and

(c) the care and treatment of mental illness in accordance with the provisions of Title 33, chapter 22, part 7.

(8) (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 (8)(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 (8).

(d) For purposes of this subsection (8):

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

(9) Upon renewal, an insurance contract or plan issued under this part under which coverage of a dependent terminates at a specified age must continue to provide coverage for any dependent, as defined in the insurance contract or plan, until the dependent reaches 26 years of age. For insurance contracts or plans issued under this part, the premium charged for the additional coverage of a dependent, as defined in the insurance contract or plan, may be required to be paid by the insured and not by the employer.

(10) 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.

(11) The state employee group benefit plans and the Montana university system group benefits plans 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, 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.

(12) (a) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes.

(b) Coverage must include a $250 benefit for a person each year for medically necessary and prescribed outpatient self-management training and education for the treatment of diabetes.

(c) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration, and glucagon emergency kits.

(d) Nothing in subsection (12)(a), (12)(b), or (12)(c) prohibits the state or the Montana university group benefit plans from providing a greater benefit or an alternative benefit of substantially equal value, in which case subsection (12)(a), (12)(b), or (12)(c), as appropriate, does not apply.

(e) Annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy.

(f) This subsection (12) does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies offered by the state or the Montana university system as benefits to employees, retirees, and their dependents.

(13) (a) The state employee group benefit plans and the Montana university system group benefits plans that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer firefighter dies within the course and scope of employment. Except as provided in subsection (13)(b), the continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this section must provide for the same level of benefits as is available to other members of the group. Premiums charged to a spouse or dependent under this section must be the same as premiums charged to other similarly situated members of the group. Dependent special enrollment must be allowed under the terms of the

insurance contract or plan. The provisions of this subsection (13)(a) are applicable to a spouse or dependent who is insured under a COBRA continuation provision.

(b) The state employee group benefit plans and the Montana university system group benefits plans subject to the provisions of subsection (13)(a) may discontinue or not renew the coverage of a spouse or dependent only if:

(i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms of the state employee group benefit plans and the Montana university system group benefits plans or if the plans have not received timely premium payments;

(ii) the spouse or dependent has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage; or

(iii) the state employee group benefit plans and the Montana university system group benefits plans are ceasing to offer coverage in accordance with applicable state law.

(14) The state employee group benefit plans and the Montana university system group benefits plans must comply with the provisions of 33-22-153.

(15) An insurance contract or plan issued under this part and a group benefits plan issued by the Montana university system must provide mental health coverage that meets the provisions of Title 33, chapter 22, part 7. (See compiler's comments for contingent termination of certain text.)"

Section 2. Section 33-22-702, MCA, is amended to read:

"**33-22-702. Definitions.** For purposes of this part, the following definitions apply:

(1) "Inpatient benefits" are as set forth in 33-22-705.

(2) "Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness or severe mental illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by a qualified health care provider and a treatment facility that is:

(a) licensed as a mental health treatment center by the state;

(b) funded or eligible for funding under federal or state law; or

(c) affiliated with a hospital under a contractual agreement with an established system for patient

referral.

(3) (a) "Mental illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

(i) present distress or a painful symptom;

(ii) a disability or impairment in one or more areas of functioning; or

(iii) a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

(b) Mental illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

(c) Mental illness does not include:

(i) a developmental disorder;

(ii) a speech disorder;

(iii) a psychoactive substance use disorder;

(iv) an eating disorder, except for bulimia and anorexia nervosa; or

(v) an impulse control disorder, except for intermittent explosive disorder and trichotillomania.

(4) "Outpatient benefits" are as set forth in 33-22-705.

(5) "Primary care behavioral health model" means an evidence-based, integrated behavioral health care service delivery model delivered in primary or specialty care settings that recognizes licensed psychologists as consultants as well as direct service providers.

(6) "Psychiatric collaborative care model" means the evidence-based, integrated behavioral health service delivery method in which care:

(a) is delivered by a primary care team consisting of a primary care provider and a care manager who work in collaboration with a psychiatric consultant, including but not limited to a psychiatrist;

(b) is directed by the primary care team;

(c) includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate; and

(d) involves regular consultations between the psychiatric consultant and the primary care team to review the clinical status and care of patients and to make recommendations.

~~(5)~~(7) "Qualified health care provider" means a person licensed as a physician, psychologist, social

worker, clinical professional counselor, marriage and family therapist, or addiction counselor or another appropriate licensed health care practitioner.

~~(6)~~(8) "Severe mental illness" means the following disorders as defined by the American psychiatric association:

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism.

~~(7)~~(9) ~~(a)~~ "Substance use disorder" means the uncontrollable or excessive use of an addictive substance, including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers, or hallucinogens, and the resultant physiological or psychological dependency that develops with continued use of the addictive substance and that requires medical care or other appropriate treatment as determined by a licensed addiction counselor or other appropriate medical practitioner.

~~(8)~~(10) "Substance use disorder treatment center" means a treatment facility that:

(a) provides a program for the treatment of substance use disorders pursuant to a written treatment plan approved and monitored by a qualified health care provider; and

(b) is licensed or approved by the department of public health and human services under 53-24-208 or is licensed or approved by the state where the facility is located."

Section 3. Section 33-22-705, MCA, is amended to read:

"**33-22-705. Inpatient and outpatient benefits -- use of psychiatric collaborative care or primary care behavioral health model.** (1) (a) Inpatient benefits are benefits payable for charges made by:

(i) a hospital or freestanding inpatient facility for the necessary care and treatment of mental illness, severe mental illness, or substance use disorder furnished to a covered person while confined as an inpatient; or

(ii) a qualified health care provider for the necessary care and treatment of mental illness, severe mental illness, or substance use disorder furnished to a covered person while confined as an inpatient.

(b) Care and treatment of a substance use disorder in a freestanding inpatient facility must be in a substance use disorder treatment center.

(c) Inpatient benefits include payment for medically monitored and medically managed intensive inpatient services and clinically managed high-intensity residential services.

(2) Outpatient benefits are benefits payable for:

(a) reasonable charges made by a hospital for the necessary care and treatment of mental illness, severe mental illness, or substance use disorder furnished to a covered person while not confined as an inpatient;

(b) reasonable charges for services rendered or prescribed by a qualified health care provider for the necessary care and treatment for mental illness, severe mental illness, or substance use disorder furnished to a covered person while not confined as an inpatient;

(c) reasonable charges made by a mental health or substance use disorder treatment center for the necessary care and treatment of a covered person provided in the treatment center while not confined as an inpatient; ~~or~~

(d) reasonable charges for services rendered by a qualified health care provider, hospital, mental health treatment center, or substance use disorder treatment center in an acute or subacute partial hospitalization or intensive outpatient treatment setting; or

(e) reasonable charges for outpatient benefits listed in this subsection (2) that are delivered through the psychiatric collaborative care or primary care behavioral health model. The charges must be reimbursed through the use of the following common procedural terminology billing codes established by the American medical association:

(i) 99492;

(ii) 99493;

(iii) 99494;

(iv) 99484, the code for care management services for behavioral health conditions;

(v) 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, and 96171, the codes for health

behavior assessment and intervention; and

(vi) 99446, 99447, 99448, 99449, and 99451, the codes for interprofessional telephone/internet/electronic health record consultations."

Section 4. Section 33-35-306, MCA, is amended to read:

"**33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(c) Title 33, chapter 1, part 7;

(d) Title 33, chapter 2, part 23;

(e) 33-3-308;

(f) Title 33, chapter 7;

(g) Title 33, chapter 18, except 33-18-242;

(h) Title 33, chapter 19;

(i) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152, and 33-22-153; ~~and~~

(j) 33-22-512, 33-22-515, 33-22-525, and 33-22-526; and

(k) Title 33, chapter 22, part 7.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

Section 5. Effective date. [This act] is effective January 1, 2022.

- END -

I hereby certify that the within bill,

SB 217, originated in the Senate.

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Secretary of the Senate

_____

President of the Senate

Signed this _____day

of_____, 2021.

_____

Speaker of the House

Signed this _____day

of_____, 2021.

SENATE BILL NO. 217

INTRODUCED BY J. SMALL

AN ACT REVISING THE MENTAL HEALTH PARITY ACT TO INCLUDE COVERAGE OF SERVICES PROVIDED THROUGH THE PSYCHIATRIC COLLABORATIVE CARE MODEL OR PRIMARY CARE BEHAVIORAL HEALTH MODEL; REQUIRING MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND PUBLIC EMPLOYEE BENEFIT PLANS TO COMPLY WITH THE REQUIREMENTS OF THE MENTAL HEALTH PARITY ACT; AMENDING SECTIONS 2-18-704, 33-22-702, 33-22-705, AND 33-35-306, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE.