SENATE BILL NO. 249

INTRODUCED BY C. KAUFMANN

A BILL FOR AN ACT ENTITLED: "AN ACT SETTING THE MINIMUM INSURANCE PAYMENT FOR MAMMOGRAPHY EXAMINATIONS; AMENDING SECTIONS 2-18-704, 33-22-132, 33-22-1827, AND 33-31-102, 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, 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;

(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, 42 U.S.C. 1395, as amended, 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, 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~~:

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

~~(8)~~(b) ~~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~~.~~; and

(c) coverage for mammography examinations as provided in 33-22-132.

~~(9)~~(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 ~~(9)(a)~~ (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 ~~(9)~~ (8).

(d) For purposes of this subsection ~~(9)~~ (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 ~~(9)(b)~~ (8)(b) and delivered by a physician or a health care professional supervised by a physician.

~~(10)~~(9) (a) Except as provided in subsection ~~(10)(b)~~ (9)(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)~~ (9)(a).

~~(11)~~(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."

Section 2. Section 33-22-132, MCA, is amended to read:

"33-22-132. Coverage for mammography examinations. (1) 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.~~

(a) For a mammogram performed as part of a minimum mammography examination, coverage under this section must provide a minimum payment of:

(i) $180; or

(ii) the actual cost if the cost is less than $180.

(b) Coverage under this section is not subject to the durational limits, copayments, or deductibles of the insured's applicable group or individual disability policy, certificate, or membership contract.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 3. Section 33-22-1827, MCA, is amended to read:

"33-22-1827. Benefits required in basic health benefit plan. (1) The basic health benefit plan must provide at least the following benefits:

(a) coverage for the services and articles required by 33-22-1521(2);

(b) coverage for mental health and chemical dependency required by Title 33, chapter 22, part 7;

(c) coverage for conversion of benefits required by 33-22-508 and 33-22-510 or by 33-30-1007; and

(d) coverage for mammography examinations ~~required by~~ as provided in 33-22-132.

(2) The small employer carrier may determine varying levels of deductibles, copayments, maximum annual out-of-pocket expenses, maximum lifetime benefits, and other financial cost-sharing arrangements with the insured that give the basic health benefit plan a lower benefit value than the standard health benefit plan.

(3) A basic health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsections (1) and (2), as determined by the benefit value."

Section 4. Section 33-31-102, MCA, is amended to read:

"33-31-102. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Affiliation period" means a period that, under the terms of the health insurance coverage offered by

a health maintenance organization, must expire before the health insurance coverage becomes effective.

(2) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

(e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to 33-31-301(3)(e);

(f) care and treatment of mental illness, alcoholism, and drug addiction;

(g) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(h) preventive health services, including:

(i) immunizations;

(ii) well-child care from birth;

(iii) periodic health evaluations for adults;

(iv) voluntary family planning services;

(v) infertility services; and

(vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction;

(i) minimum mammography examination coverage~~,~~ as ~~defined~~ provided in 33-22-132;

(j) outpatient self-management training and education for the treatment of diabetes along with certain diabetic equipment and supplies as provided in 33-22-129; and

(k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have the meanings provided for in 33-22-131.

(3) "Commissioner" means the commissioner of insurance of the state of Montana.

(4) "Dependent" has the meaning provided in 33-22-140.

(5) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

(6) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(7) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

(8) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(9) (a) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers. This subsection does not limit methods of provider payments made by health maintenance organizations.

(b) The term does not apply to a PACE organization that has received a waiver pursuant to 33-31-201.

(10) "Insurance producer" means an individual or business entity appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(11) "PACE organization" means an organization, as defined in 42 CFR 460.6, that is authorized by the centers for medicare and medicaid services and the department of public health and human services to operate a program of all-inclusive care for the elderly.

(12) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(13) "Plan" means a health maintenance organization operated by an insurer or health service corporation as an integral part of the corporation and not as a subsidiary.

(14) "Point-of-service option" means a delivery system that permits an enrollee of a health maintenance organization to receive health care services from a provider who is, under the terms of the enrollee's contract for health care services with the health maintenance organization, not on the provider panel of the health maintenance organization.

(15) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or advanced practice registered nurse, as specifically listed in 37-8-202, who treats any illness or injury within the scope and limitations of the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

(16) "Provider panel" means those providers with whom a health maintenance organization contracts to provide health care services to the health maintenance organization's enrollees.

(17) "Purchaser" means the individual, employer, or other entity, but not the individual certificate holder in the case of group insurance, that enters into a health care services agreement.

(18) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent."

NEW SECTION. **Section 5. Effective date.** [This act] is effective January 1, 2012.

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