SENATE BILL NO. 280

INTRODUCED BY A. OLSZEWSKI

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE "ENSURING ACCESS TO HIGH-QUALITY CARE FOR THE TREATMENT OF SUBSTANCE USE DISORDERS ACT"; REQUIRING INSURANCE AND MEDICAID COVERAGE OF MEDICATION-ASSISTED TREATMENT; ESTABLISHING REQUIREMENTS FOR ASSESSMENTS BY SUBSTANCE USE DISORDER TREATMENT FACILITIES; AMENDING SECTIONS 2-18-704, 33-1-501, 33-22-201, 33-22-502, 33-31-111, 33-35-306, 50-5-103, 50-5-207, 53-6-101, AND 53-24-208, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Short title.** [Sections 1 through 9] may be cited as the "Ensuring Access to High-Quality Care for the Treatment of Substance Use Disorders Act".

NEW SECTION. **Section 2. Purpose.** It is the purpose of [sections 1 through 9] to enhance efforts to prevent and comprehensively treat opioid-related substance use disorders, including the use of medication-assisted treatment for opioid addiction, in order to reduce opioid-related misuse, overdose, and death as well as accidental injury and death from other drugs.

NEW SECTION. **Section 3. Definitions.** As used in [sections 1 through 9], the following definitions apply:

(1) "Behavioral therapy" means an individual, family, or group therapy designed to help a patient engage in the treatment process, modify the patient's attitudes and behaviors related to substance use, and increase healthy life skills.

(2) "Commissioner" means the commissioner of insurance of this state.

(3) "Coverage" means benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, though insurance, reimbursement, or otherwise under a policy, certificate, membership contract or other plan offered by a health insurer.

(4) "Financial requirements" means deductibles, copayments, coinsurance, or out-of-pocket maximum

requirements.

(5) "Health care provider" or "provider" means an individual licensed under Title 37 to provide health care in the ordinary course of business or practice of a profession.

(6) "Health insurer" or "insurer" means any person or entity that issues, offers, delivers, or administers a health insurance plan under Title 33 or Title 2, chapter 18, part 7 or 8.

(7) "Medication-assisted treatment" means the use of pharmacologic therapy in combination with counseling and behavioral therapy for the treatment of substance use disorder by a publicly or privately owned opioid treatment program or office-based medication-assisted treatment program.

(8) "Nonquantitative treatment limitation" means any limitation on the scope or duration of treatment that is not expressed numerically.

(9) "Opioid treatment program" means a program that is accredited by the federal substance abuse and mental health services administration and licensed to dispense methadone and other medications for the treatment of opioid use disorders.

(10) "Pharmacologic therapy" means a prescribed course of treatment that may include methadone, buprenorphine, extended-release injectable buprenorphine, naltrexone, naloxone, or other medications that are approved by the U.S. food and drug administration or considered evidence-based for the treatment of substance use disorder.

(11) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of a health insurance issuer, third-party administrator, or plan sponsor to process claims for prescription drugs, provide retail network management for pharmacies or pharmacists, and pay pharmacies or pharmacists for prescription drugs.

(12) (a) "Prior authorization" means the process by which a health insurer or pharmacy benefit manager determines the medical necessity of otherwise covered health care services before the services are provided.

(b) The term includes a health insurer's or utilization review entity's requirement that an insured or health care provider notify the health insurer or utilization review entity prior to receiving or providing a health care service.

(13) "Quantitative treatment limitation" means numerical limits on the scope or duration of treatment, including annual, episode, and lifetime day and visit limits.

(14) "Step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a medical condition that are medically appropriate for a particular patient are authorized by a health insurer or pharmacy benefit manager.

(15) (a) "Urgent health care service" means a health care service or course of treatment that if not provided within 24 hours could, in the opinion of a health care provider with knowledge of the insured's medical condition:

(i) seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or

(ii) subject the insured to severe pain that cannot be adequately managed without the care or treatment.

(b) The term includes services provided for the treatment of substance use disorders.

NEW SECTION. **Section 4. Health insurance and medicaid coverage of medication-assisted treatment services.** (1) A health insurer shall provide coverage of medication-assisted treatment that includes pharmacologic and behavioral therapies as required under this section.

(2) A formulary used by a health insurer or managed by a pharmacy benefit manager must include all current and new formulations and medications approved by the U.S. food and drug administration for the treatment of substance use disorder, including but not limited to:

(a) buprenorphine, including extended-release injectable buprenorphine;

(b) methadone;

(c) naloxone;

(d) extended-release injectable naltrexone; and

(e) buprenorphine and naloxone in combination.

(3) An insurer or pharmacy benefit manager shall place all medication-assisted treatment medications required for compliance under [sections 1 through 9] on the lowest cost-sharing tier of the formulary managed by the insurer or the pharmacy benefit manager.

(4) Coverage for medication-assisted treatment under [sections 1 through 9] may not be subject to:

(a) annual or lifetime dollar limitations;

(b) limitations to a predesignated facility, specific number of visits, days of coverage, days in a waiting period, scope or duration of treatment, or other similar limits;

(c) financial requirements and quantitative treatment limitations that do not comply with the federal Mental Health Parity and Addiction Equity Act of 2008 and 45 CFR 146.136(c)(3);

(d) step therapy or other similar drug utilization strategies or policies when they conflict or interfere with a prescribed or recommended course of treatment by a health care provider; or

(e) prior authorization.

(5) (a) The medicaid program provided for in Title 53, chapter 6, part 1, shall provide coverage of medicaid-assisted treatment as provided in this section.

(b) The medicaid program shall provide medication-assisted treatment medications in its preferred drug list for the treatment of substance use disorders and prevention of drug overdose and death. The preferred drug list must include, at a minimum, all current and new formulations and medications that are approved by the U.S. food and drug administration for the treatment of substance use disorder.

(6) A health insurer and the medicaid program shall provide coverage of medication-assisted treatment as required under this section regardless of whether an individual previously received similar treatment or services.

NEW SECTION. **Section 5. Network requirements -- limitation on patient payments.** (1) A health insurer shall disclose to insureds:

(a) which health care providers in its provider network offer medication-assisted treatment; and

(b) what level of care is provided in accordance with criteria developed by the American society of addiction medicine or other nationally recognized, research-validated substance use disorder-specific program standards recognized by the applicable
licensing bodies for the health care providers.

(2) The disclosure required under this section must be made in a prominent manner on the insurer's website and in its print and electronic directories of providers.

(3) A provider network must meet maximum time and distance standards and minimum wait time standards, as established by the commissioner by rule, for providers of medication-assisted treatment. The commissioner shall review the standards every 2 years to ensure patient access to medication-assisted treatment services.

(4) A health insurer shall include with the form filed with the commissioner pursuant to 33-1-501 a description of how its provider network meets the requirements of this section.

(5) A health insurer shall have a process to ensure that an insured is able to obtain a covered benefit for medication-assisted treatment at an in-network level of coverage. The insurer shall make arrangements as approved by the commissioner when coverage offered by the insurer:

(a) has an otherwise sufficient network but does not have:

(i) an appropriate type of in-network provider available to provide the covered medication-assisted treatment services; or

(ii) an in-network provider available to provide the covered services without unreasonable travel or delay; or

(b) has an insufficient number or type of appropriate in-network providers available to provide the services without unreasonable travel or delay.

(6) When a health insurer's network is inadequate to meet the requirements of this section, the insurer shall treat the health care services an insured receives from an out-of-network provider pursuant to this section as if the services were provided by an in-network provider, including counting the insured's cost-sharing for the services toward the insured's deductible and maximum out-of-pocket limit applicable to services obtained from in-network providers.

(7) A health insurer shall review and make a determination within 24 hours on any request from an insured or an insured's health care provider related to the insured's coverage for:

(a) urgent health care services for medication-assisted treatment; or

(b) medication-assisted treatment from an out-of-network provider.

(8) The insurer shall report annually to the commissioner on the frequency with which the insurer:

(a) paid the in-network rate for medication-assisted treatment because the insurer's provider network was inadequate under the requirements of [sections 1 through 9]; and

(b) reviewed requests for urgent health care services or out-of-network services as provided under subsection (7).

NEW SECTION. **Section 6. Substance use disorder and mental health parity reporting requirements -- commissioner review -- public disclosure.** (1) A health insurer subject to the requirements of [sections 1 through 9] shall submit an annual report to the commissioner that:

(a) describes the process used to develop or select the medical necessity criteria for mental health and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(b) identifies nonquantitative treatment limitations that are applied to mental health and substance use disorder benefits; and

(c) provides an analysis that demonstrates that for the medical necessity criteria and each

nonquantitative treatment limitation, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each limitation to mental health and substance use disorder benefits within each classification of benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each limitation to medical and surgical benefits within the corresponding classification of benefits.

(2) At a minimum, the results of the analysis required under subsection (1)(c) must:

(a) identify how the factors used to determine that nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

(b) identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative limitation;

(c) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative limitation, as written, for mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits; and

(d) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits.

(3) The commissioner shall publish the specific findings and conclusions reached by each health insurer.

(4) The commissioner shall periodically perform parity compliance with market conduct examinations of all health insurers that provide coverage for mental health and substance use disorder care in this state with a focus on determining compliance the requirements of [sections 1 through 9].

(5) The commissioner shall promote and include in a prominent location on the website of the office of state auditor a mechanism to explain the requirements of [sections 1 through 9]. The mechanism must include a means for consumers and health care providers to file a complaint with the commissioner when an insurer fails to meet the requirements of [sections 1 through 9].

NEW SECTION. **Section 7. Policies null and unenforceable.** Any provision, written policy, or written

procedure of a health care policy that violates the provisions of [sections 1 through 9] is considered unenforceable and is void.

NEW SECTION. **Section 8. Treatment facility requirements.** Any entity providing treatment or that applies for licensure by the state to provide clinical treatment services for substance use disorders:

(1) shall use criteria established by the American society of addiction medicine for:

(a) providing outcome-oriented and results-based care in the treatment of addiction; and

(b) placement, continued stay, and transfer or discharge of patients with addiction and co-occurring conditions;

(2) shall disclose the medication-assisted treatment services it provides;

(3) shall disclose which of its levels of care have been certified by an independent, national, or other organization that has competencies in the use of the applicable placement guidelines and level of care standards; and

(4) may not deny access to medication-assisted treatment if a patient meets clinically appropriate criteria for treating substance use disorders through medication-assisted treatment.

NEW SECTION. **Section 9. Rulemaking.** (1) The commissioner shall adopt rules to implement and enforce the requirements of [sections 1 through 9], including but not limited to rules:

(a) establishing the time, distance, and waiting time standards for receiving in-network medication-assisted treatment services;

(b) establishing allowable arrangements for alternatives to receiving services from an in-network provider; and

(c) the form of the report required under [section 6] and the manner and date for filing the report.

(2) The commissioner shall consult with representatives of organizations for mental health, health care, social work, and other interested parties in proposing rules to carry out the requirements of [sections 1 through 9].

Section 10. 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.

(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.

(16) The state employee group benefit plans and the Montana university system group benefits plans must comply with the requirements of [sections 1 through 9]. (See compiler's comments for contingent termination of certain text.)"

Section 11. Section 33-1-501, MCA, is amended to read:

"33-1-501. Filing of forms -- approval -- review of disapproval or withdrawal of approval -- application. (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form and, for the purposes of disability insurance, an outline of coverage as required by 33-22-244 and 33-22-521 and the report required under [section 6] have been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer or the interstate

insurance product regulation commission provided for in 33-39-101. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, other than ocean marine and foreign trade coverages, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

(b) A filing required by subsection (1)(a) must be submitted by an officer of the insurer with a certification in a form prescribed by the commissioner. The certification must state that to the best of the officer's knowledge and belief, the policy, contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate complies with the applicable provisions of Title 33.

(c) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

(2) (a) The filing must be made not less than 60 days before delivery and must be delivered by hand or sent by certified mail with a return receipt requested. The commissioner's office shall mark a filing with the date of receipt by the commissioner's office.

(b) (i) If after 60 days from the date of receipt by the commissioner's office the commissioner has not approved or disapproved the form by a notice pursuant to the provisions in subsection (4), the form is considered approved for all purposes, subject to subsection (2)(c).

(ii) The running of the 60-day period is tolled for a period commencing on the date that the commissioner notifies the insurer of problems or questions and requests additional information from the insurer concerning a form filed pursuant to subsection (1)(a) and ending on the date that the insurer submits its response to the commissioner.

(iii) For purposes of tolling the 60-day period as provided in subsection (2)(b)(ii), the commissioner's request notification may be made electronically.

(c) In a letter separate from the original filing and delivered by hand or sent by certified mail with return receipt requested, the insurer shall notify the commissioner, at least 10 days before the use of the form in the

market, that the insurer believes that:

(i) the form has been or will be considered approved; and

(ii) the insurer will begin marketing the form in Montana.

(d) The commissioner's office shall mark a letter received pursuant to subsection (2)(c) with the date of receipt by the commissioner's office.

(3) Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the waiting period.

(4) The commissioner may at any time, after notice and for cause shown, withdraw any approval. Notice by the commissioner disapproving a form or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer of the specific reason or reasons for and the legal authority supporting the disapproval or withdrawal of approval in whole or in part. The disapproval or withdrawal of approval does not take effect unless it is issued after the commissioner has reviewed the form and provided notice to the person who filed the form pursuant to 33-1-314 and this subsection.

(5) After the date of the insurer's receipt of notice of disapproval or withdrawal of approval by the commissioner, the insurer may not deliver the form or issue the form for delivery in Montana.

(6) The insurer may request a hearing, as provided for in 33-1-701, for unresolved disputes regarding a disapproval or a withdrawal of approval.

(7) The commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form to which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval of which are not desirable or necessary for the protection of the public.

(8) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by the official and upon the commissioner's order requiring the form to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply to forms for domestic use.

(9) Section 33-1-502 and this section do not apply to:

(a) reinsurance;

(b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection (8);

(c) ocean marine and foreign trade insurances.

(10) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner upon request. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law."

Section 12. 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) 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.

(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.

(8) The policy complies with the requirements of [sections 1 through 9]."

Section 13. Section 33-22-502, MCA, is amended to read:

"33-22-502. Required provisions of group policies. Each group disability insurance policy delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person must be considered representations and not warranties and that a statement made for the purpose of effecting insurance may not avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the insured person or the insured person's beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits are payable. If dependents are included in the coverage, only one certificate is required to be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy;

(4) a provision or the equivalent that reads:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

(5) a provision that the policy complies with the requirements of [sections 1 through 9]. "

Section 14. Section 33-31-111, MCA, is amended to read:

"33-31-111. 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 Title 33, chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, parts 7 and 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) Title 33, chapter 1, parts 12 and 13, 33-2-1114, 33-2-1211, 33-2-1212, Title 33, chapter 2, parts 13, 19, and 23, 33-3-401, 33-3-422, 33-3-431, Title 33, chapter 3, part 6, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152, 33-22-153, 33-22-156 through 33-22-159, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and Title 33, chapter 32, apply to health maintenance organizations; or

(8) [sections 1 through 9]."

Section 15. Section 33-35-306, MCA, is amended to read:

"33-35-306. Application of insurance code and other state laws 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) [sections 1 through 9].

(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 16. Section 50-5-103, MCA, is amended to read:

"50-5-103. Rules and standards -- accreditation. (1) The department shall adopt rules and minimum standards for implementation of parts 1 and 2.

(2) Any facility covered by this chapter shall comply with the state and federal requirements relating to construction, equipment, and fire and life safety.

(3) The department shall extend a reasonable time for compliance with rules for parts 1 and 2 upon adoption.

(4) (a) Any hospital located in this state that furnishes written evidence required by the department, including the recommendation for future compliance statements, to the department of its accreditation granted by an entity listed in subsection (4)(b) is eligible for licensure in the state for the accreditation period and may not be subjected to an inspection by the department for purposes of the licensing process.

(b) A hospital may provide evidence of its accreditation by:

(i) DNV healthcare, inc.;

(ii) the healthcare facilities accreditation program; or

(iii) the joint commission.

(c) The department may, in addition to its inspection authority in 50-5-116, inspect any licensed health

care facility to answer specific complaints made in writing by any person against the facility when the complaints pertain to licensing requirements. Inspection by the department upon a specific complaint made in writing pertaining to licensing requirements is limited to the specific area or condition of the health care facility to which the complaint pertains.

(5) The department may consider as eligible for licensure during the accreditation period any health care facility located in this state, other than a hospital, that furnishes written evidence, including the recommendation for future compliance statements, of its accreditation by the joint commission. The department may inspect a health care facility considered eligible for licensure under this section to ensure compliance with state licensure standards.

(6) The department may consider as eligible for licensure during the accreditation period any rehabilitation facility that furnishes written evidence, including the recommendation for future compliance statements, of accreditation of its programs by the commission on accreditation of rehabilitation facilities. The department may inspect a rehabilitation facility considered eligible for licensure under this section to ensure compliance with state licensure standards.

(7) The department may consider as eligible for licensure during the accreditation period any outpatient center for surgical services that furnishes written evidence, including the recommendation for future compliance statements, of accreditation of its programs by the accreditation association for ambulatory health care. The department may inspect an outpatient center for surgical services considered eligible for licensure under this section to ensure compliance with state licensure standards.

(8) The department may consider as eligible for licensure during the accreditation period any behavioral treatment program, chemical dependency treatment program, residential treatment facility, or mental health center that furnishes written evidence, including the recommendation for future compliance statements, of accreditation of its programs by the council on accreditation and that, if applicable, meets the requirements of [section 8]. The department may inspect a behavioral treatment program, chemical dependency treatment program, residential treatment facility, or mental health center considered eligible for licensure under this section to ensure compliance with state licensure standards."

Section 17. Section 50-5-207, MCA, is amended to read:

"50-5-207. Denial, suspension, or revocation of health care facility license -- provisional license. (1) The department may deny, suspend, or revoke a health care facility license if any of the following

circumstances exist:

(a) The facility fails to meet the minimum standards pertaining to it prescribed under 50-5-103.

(b) The staff is insufficient in number or unqualified by lack of training or experience.

(c) The applicant or any person managing it has been convicted of a felony and denial of a license on that basis is consistent with 37-1-203 or the applicant otherwise shows evidence of character traits inimical to the health and safety of patients or residents.

(d) The applicant does not have the financial ability to operate the facility in accordance with law or rules or standards adopted by the department.

(e) There is cruelty or indifference affecting the welfare of the patients or residents.

(f) There is misappropriation of the property or funds of a patient or resident.

(g) There is conversion of the property of a patient or resident without the patient's or resident's consent.

(h) Any provision of parts 1 through 3 is violated.

(i) The applicant plans to provide treatment for substance use disorders and does not meet the requirements of [section 8].

(2) The department may reduce a license to provisional status if as a result of an inspection it is determined that the facility has failed to comply with a provision of part 1 or 2 of this chapter or has failed to comply with a rule, license provision, or order adopted or issued pursuant to part 1 or 2.

(3) The denial, suspension, or revocation of a health care facility license is not subject to the certificate of need requirements of part 3.

(4) The department may provide in its revocation order that the revocation is in effect for up to 2 years. If this provision is appealed, it must be affirmed or reversed by the court."

Section 18. Section 53-6-101, MCA, is amended to read:

"53-6-101. Montana medicaid program -- authorization of services. (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq. The department shall administer the Montana medicaid program.

(2) The department and the legislature shall consider the following funding principles when considering changes in medicaid policy that either increase or reduce services:

(a) protecting those persons who are most vulnerable and most in need, as defined by a combination of economic, social, and medical circumstances;

(b) giving preference to the elimination or restoration of an entire medicaid program or service, rather than sacrifice or augment the quality of care for several programs or services through dilution of funding; and

(c) giving priority to services that employ the science of prevention to reduce disability and illness, services that treat life-threatening conditions, and services that support independent or assisted living, including pain management, to reduce the need for acute inpatient or residential care.

(3) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined in 33-22-132;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age, in accordance with federal regulations and subsection (10)(b);

(h) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;

(j) services that are provided by physician assistants within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(k) health services provided under a physician's orders by a public health department;

(l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2);

(m) routine patient costs for qualified individuals enrolled in an approved clinical trial for cancer as provided in 33-22-153; ~~and~~

(n) for children 18 years of age and younger, habilitative services as defined in 53-4-1103; and

(o) treatment for substance use disorders that complies with the requirements of [sections 1 through 9].

(4) Medical assistance provided by the Montana medicaid program may, as provided by department rule,

also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 10;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23;

(m) hospice care, as defined in 42 U.S.C. 1396d(o);

(n) case management services, as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case management services for the mentally ill;

(o) services of psychologists licensed under Title 37, chapter 17;

(p) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201; and

(q) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(5) Services for persons qualifying for medicaid under the medically needy category of assistance, as described in 53-6-131, may be more limited in amount, scope, and duration than services provided to others qualifying for assistance under the Montana medicaid program. The department is not required to provide all of the services listed in subsections (3) and (4) to persons qualifying for medicaid under the medically needy category of assistance.

(6) In accordance with federal law or waivers of federal law that are granted by the secretary of the U.S. department of health and human services, the department may implement limited medicaid benefits, to be known as basic medicaid, for adult recipients who are eligible because they are receiving financial assistance, as defined

in 53-4-201, as the specified caretaker relative of a dependent child under the FAIM project and for all adult recipients of medical assistance only who are covered under a group related to a program providing financial assistance, as defined in 53-4-201. Basic medicaid benefits consist of all mandatory services listed in subsection (3) but may include those optional services listed in subsections (4)(a) through (4)(q) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature, whether approval has been received, as provided in 53-1-612, and whether the provision of a particular service is commonly covered by private health insurance plans. However, a recipient who is pregnant, meets the criteria for disability provided in Title II of the Social Security Act, 42 U.S.C. 416, et seq., or is less than 21 years of age is entitled to full medicaid coverage.

(7) The department may implement, as provided for in Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(8) (a) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(b) The department shall strive to close gaps in services provided to individuals suffering from mental illness and co-occurring disorders by doing the following:

(i) simplifying administrative rules, payment methods, and contracting processes for providing services to individuals of different ages, diagnoses, and treatments. Any adjustments to payments must be cost-neutral for the biennium beginning July 1, 2017.

(ii) publishing a report on an annual basis that describes the process that a mental health center or chemical dependency facility, as those terms are defined in 50-5-101, must utilize in order to receive payment from Montana medicaid for services provided to individuals of different ages, diagnoses, and treatments.

(9) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost-effective.

(10) (a) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the Social Security Act, 42 U.S.C. 1396, et seq., as may be amended.

(b) The department shall, with reasonable promptness, provide access to all medically necessary services prescribed under the early and periodic screening, diagnosis, and treatment benefit, including access to prescription drugs and durable medical equipment for which the department has not negotiated a rebate.

(11) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(12) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program after taking into consideration the funding principles set forth in subsection (2)."

Section 19. Section 53-24-208, MCA, is amended to read:

"53-24-208. Facility standards. (1) The department shall: ~~establish standards for~~

(a) require approved treatment facilities to meet the requirements of [section 8];

(b) establish other standards that must be met for a treatment facility to be approved as a public or private treatment facility; and

(c) fix the fees to be charged for the required inspections.

(2) The standards must be adopted by rule and may concern the health standards to be met and standards for the approval of treatment programs for patients.

~~(2)~~(3) Facilities applying for approval shall demonstrate that a local need currently exists for proposed services.

~~(3)~~(4) The department shall periodically inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

~~(4)~~(5) The department shall maintain a list of approved public and private treatment facilities.

~~(5)~~(6) Each approved public or private treatment facility shall, on request, file with the department data, statistics, schedules, and information that the department reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested or files fraudulent returns of the requested material must be removed from the list of approved treatment facilities.

~~(6)~~(7) The department, after holding a hearing in accordance with the Montana Administrative Procedure Act, may suspend, revoke, limit, or restrict an approval or refuse to grant an approval for failure to meet its standards.

~~(7)~~(8) A district court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

~~(8)~~(9) Upon petition of the department and after a hearing held upon reasonable notice to the facility, a district court may issue a warrant to the department authorizing it to enter and inspect at reasonable times and

examine the books and accounts of any approved public or private treatment facility that refuses to consent to inspection or examination by the department or that the department has reasonable cause to believe is operating in violation of this chapter.

~~(9)~~(10) If a rehabilitation facility otherwise meets the requirement in subsection ~~(2)~~ (3), the department may consider as eligible for approval during the accreditation period any rehabilitation facility that furnishes written evidence, including the recommendation for future compliance statements, of accreditation of its programs by the commission on accreditation of rehabilitation facilities. The department shall inspect a facility considered eligible for approval under this section to ensure compliance with state approval standards."

NEW SECTION. **Section 20. Codification instruction.** [Sections 1 through 9] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [sections 1 through 9].

NEW SECTION. **Section 21. Effective date.** [This act] is effective January 1, 2020.

NEW SECTION. **Section 22. Applicability.** [Section 7] applies to contracts, policies, or procedures issued or prepared on or after January 1, 2020.

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