

1 SENATE BILL NO. 310

2 INTRODUCED BY M. WATERMAN, BECK, CHRISTIAENS, FRANKLIN, KEENAN, F. THOMAS, WITT

3

4 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING PROVISIONS REGARDING THE
5 MONTANA COMPREHENSIVE HEALTH ASSOCIATION; APPLYING MANDATORY COVERAGE FOR SEVERE
6 MENTAL ILLNESS TO THE ASSOCIATION; REVISING THE 1 PERCENT ASSESSMENT AMOUNT TO A CAP
7 THAT THE ASSESSMENT MAY NOT EXCEED; REMOVING THE ABILITY TO ABATE AN EXCESS
8 ASSESSMENT; ALLOWING THE ASSOCIATION TO CHARGE LATE PAYMENT PENALTIES, INTEREST, OR
9 BOTH; PROVIDING RULEMAKING AUTHORITY REGARDING LATE PAYMENTS AND INTEREST CHARGES;
10 RAISING THE AMOUNT TO \$50 UNDER WHICH AN ASSESSMENT NEED NOT BE LEVIED; RAISING THE
11 MAXIMUM PHARMACY BENEFIT TO \$2,000; AMENDING SECTIONS 33-22-706, 33-22-1502,
12 33-22-1513, AND 33-22-1521, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

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16 **Section 1.** Section 33-22-706, MCA, is amended to read:

17 **"33-22-706. Coverage for severe mental illness -- definition.** (1) A policy or certificate of health
18 insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in
19 this state must provide a level of benefits for the necessary care and treatment of severe mental illness,
20 as defined in subsection (6), that is no less favorable than that level provided for other physical illness
21 generally. Benefits for treatment of severe mental illness may be subject to managed care provisions
22 contained in the policy or certificate.

23 (2) Benefits provided pursuant to subsection (1) include but are not limited to:

24 (a) inpatient hospital services;

25 (b) outpatient services;

26 (c) rehabilitative services;

27 (d) medication;

28 (e) services rendered by a licensed physician, licensed advanced practice registered nurse with
29 a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional
30 counselor when those services are part of a treatment plan recommended and authorized by a licensed

1 physician; and

2 (f) services rendered by a licensed advanced practice registered nurse with prescriptive authority
3 and specializing in mental health.

4 (3) Benefits provided pursuant to this section must be included when determining maximum
5 lifetime benefits, copayments, and deductibles.

6 (4) (a) This section applies to health service benefits provided by:

7 (i) individual and group health and disability insurance;

8 (ii) individual and group hospital or medical expense insurance;

9 (iii) medical subscriber contracts;

10 (iv) membership contracts of a health service corporation; ~~and~~

11 (v) health maintenance organizations; and

12 (vi) the comprehensive health association created by 33-22-1503.

13 (b) This section does not apply to the following coverages:

14 (i) blanket;

15 (ii) short-term travel;

16 (iii) accident only;

17 (iv) limited or specific disease;

18 (v) Title XVIII of the Social Security Act (medicare); or

19 (vi) any other similar coverage under state or federal government plans.

20 (5) This section does not limit benefits for an illness or condition that does not constitute a severe
21 mental illness, as defined in subsection (6), but that does constitute a mental illness, as defined in
22 33-22-702.

23 (6) As used in this section, "severe mental illness" means the following disorders as defined by
24 the American psychiatric association:

25 (a) schizophrenia;

26 (b) schizoaffective disorder;

27 (c) bipolar disorder;

28 (d) major depression;

29 (e) panic disorder;

30 (f) obsessive-compulsive disorder; and

1 (g) autism."

2

3 **Section 2.** Section 33-22-1502, MCA, is amended to read:

4 **"33-22-1502. Duties of the commissioner -- rules.** The commissioner shall:

5 (1) adopt rules to carry out the provisions and purposes of this part, including rules regarding late
6 payment penalties or rates of interest charged on unpaid assessments;

7 (2) supervise the creation of the association within the limits described in 33-22-1503;

8 (3) approve the selection of the lead carrier by the association and approve the association's
9 contract with the lead carrier, including the association plan coverage and premiums to be charged;

10 (4) conduct periodic audits to ~~assure~~ ensure the general accuracy of the financial data submitted
11 by the lead carrier and the association; and

12 (5) undertake, directly or through contracts with other persons, studies or demonstration projects
13 to develop awareness of the benefits of this part so that the residents of this state may best avail
14 themselves of the health care benefits provided by this part."

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16 **Section 3.** Section 33-22-1513, MCA, is amended to read:

17 **"33-22-1513. Operation of association plan and association portability plans.** (1) Upon acceptance
18 by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of
19 the association plan premium to the lead carrier.

20 (2) Upon application by a federally defined eligible individual to the lead carrier for an association
21 portability plan, the association may not:

22 (a) decline to offer an association portability plan; or

23 (b) impose a preexisting condition exclusion with respect to an individual's association portability
24 plan coverage if application for association portability plan coverage is made within 63 days following
25 termination of the applicant's most recent prior creditable coverage.

26 (3) Not less than 88% of the association plan premiums paid to the lead carrier may be used to
27 pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect
28 expenses as specified in 33-22-1514.

29 (4) Any income in excess of the costs incurred by the association in providing reinsurance or
30 administrative services must be held at interest and used by the association to offset past and future

1 losses due to claims expenses of the association plan and the association portability plan or be allocated
2 to reduce association plan premiums.

3 (5) (a) Each participating member of the association shall share the losses due to claims expenses
4 of the association plan and the association portability plan for plans issued or approved for issuance by
5 the association and shall share in the operating and administrative expenses incurred or estimated to be
6 incurred by the association incident to the conduct of its affairs in the following manner:

7 (i) Each participating member of the association must be assessed by the association on an annual
8 basis an amount ~~equal to~~ not to exceed 1% of the association member's total disability insurance premium
9 received from or on behalf of Montana residents as determined by the commissioner. Assessments made
10 under this subsection (5)(a) or funds from any other source must be allocated to the association plan and
11 the association portability plan in proportion to the needs of the two plans. If the needs of the association
12 plan and the association portability plan exceed the funds generated by the 1% assessment, the
13 association is then authorized to spend any funds appropriated by the legislature for the support of the
14 plans.

15 ~~(ii) The association may abate, in whole or in part, the 1% assessment if the needs of the~~
16 ~~association plan and the association portability plan do not require the funds generated by the full 1%~~
17 ~~assessment. The commissioner shall approve any abatement of the 1% assessment.~~

18 ~~(iii)(ii) (A)~~ Payment of an assessment is due within 30 days of receipt by a member of a written
19 notice of the annual assessment. After 30 days, the association shall charge a member a late payment
20 penalty of:

21 (I) A LATE PAYMENT PENALTY OF 1.5% a month or fraction of a month on the unpaid assessment, not
22 to exceed 18% of the assessment due;

23 (II) interest at the rate of 12% a year on the unpaid assessment, to be accrued at 1% a month or
24 fraction of a month; or

25 (III) a late payment penalty and interest BOTH OF THE CHARGES IN SUBSECTIONS (5)(A)(II)(A)(I) AND
26 (5)(A)(II)(A)(II).

27 (B) Failure by a contributing member to tender the association assessment within the 30-day
28 period is grounds for termination of membership. A member terminated for failure to tender the association
29 assessment is ineligible to write health care benefit policies or contracts in this state under 33-22-1503(2).

30 ~~(iv)(iii)~~ An associate member that ceases to do disability insurance business within the state

1 remains liable for assessments through the calendar year in which the member ceased doing disability
 2 insurance business. The association may decline to levy an assessment against an association member if
 3 the assessment, as determined pursuant to this section, would not exceed ~~\$10~~ \$50.

4 (b) For purposes of this subsection (5), "total disability insurance premium" does not include
 5 premiums received from disability income insurance, credit disability insurance, disability waiver insurance,
 6 life insurance, medicare risk or other similar medicare health maintenance organization payments, or
 7 medicaid health maintenance organization payments.

8 (c) Any income in excess of the incurred or estimated claims expenses of the association plan and
 9 the association portability plan and the operating and administrative expenses of the association must be
 10 held at interest and used by the association to offset past and future losses due to claims expenses of the
 11 association plan and the association portability plan or be allocated to reduce association plan premiums.

12 (6) The proportion of the annual assessment allocated to the operation and expenses of the
 13 association plan, not to include any amount of late payment penalty or interest charged, may be offset by
 14 an association member against the premium tax payable by that association member pursuant to 33-2-705
 15 for the year in which the annual assessment is levied. The insurance commissioner shall report to the office
 16 of budget and program planning, as a part of the information required by 17-7-111, the total amount of
 17 premium tax offset claimed by association members during the preceding biennium. The proportion of the
 18 annual assessment allocated to the operation and expenses of the association portability plan and levied
 19 against an association member may not be offset against the premium tax payable by that association
 20 member."

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22 **Section 4.** Section 33-22-1521, MCA, is amended to read:

23 **"33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified
 24 as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting ~~part~~
 25 ~~7 33-22-701 through 33-22-705~~), and 30, and other laws of this state, whether or not the policy is issued
 26 in this state, and meets or exceeds the following minimum standards:

27 (1) (a) The minimum benefits for an insured must, subject to the other provisions of this section,
 28 be equal to at least 50% of the covered expenses required by this section in excess of an annual
 29 deductible that does not exceed \$1,000 per person. The coverage must include a limitation of \$5,000 per
 30 person on the total annual out-of-pocket expenses for services covered under this section. Coverage must

1 be subject to a maximum lifetime benefit, but the maximums may not be less than \$100,000.

2 (b) One association plan must be offered with coverage for 80% of the covered expenses provided
3 in this section in excess of an annual deductible that does not exceed \$1,000 per person. This association
4 plan must provide a maximum lifetime benefit of at least \$500,000.

5 (c) Covered expenses for plans under subsection (1)(a) and (1)(b) must be paid as specified in
6 provider contracts or, in the absence of a provider contract, at the prevailing charge in the state where
7 the service is provided.

8 (d) The board may authorize other association plans, including managed care plans as defined in
9 33-36-103.

10 (2) Covered expenses for plans offered under subsections (1)(a) and (1)(b) must be for the
11 following medically necessary services and articles when prescribed by a physician or other licensed health
12 care professional and when designated in the contract:

13 (a) hospital services;

14 (b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than
15 dental;

16 (c) use of radium or other radioactive materials;

17 (d) oxygen;

18 (e) anesthetics;

19 (f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

20 (g) services of a physical therapist;

21 (h) transportation provided by licensed ambulance service to the nearest facility qualified to treat
22 the condition;

23 (i) oral surgery for the gums and tissues of the mouth when not performed in connection with the
24 extraction or repair of teeth or in connection with TMJ;

25 (j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible
26 has been met at the rate of 50%, up to a maximum of \$1,000;

27 (k) prosthetics, other than dental;

28 (l) services of a licensed home health agency, up to a maximum of 180 visits per year;

29 (m) drugs requiring a physician's prescription that are approved for use in human beings in the
30 manner prescribed by the United States food and drug administration, covered at 50% of the expense, up

1 to an annual maximum of ~~\$1,000~~ \$2,000;

2 (n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung,
3 lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime
4 maximum of \$150,000, with an additional benefit not to exceed \$10,000 for expenses associated with
5 the donor;

6 (o) pregnancy, including complications of pregnancy;

7 (p) newborn infant coverage, as required by 33-22-301;

8 (q) sterilization;

9 (r) immunizations;

10 (s) outpatient rehabilitation therapy;

11 (t) foot care for diabetics;

12 (u) services of a convalescent home, as an alternative to hospital services, limited to a maximum
13 of 60 days per year; ~~and~~

14 (v) travel, other than transportation by a licensed ambulance service, to the nearest facility
15 qualified to treat the patients medical condition when approved in advance by the insurer; and

16 (w) coverage for severe mental illness as required in 33-22-706.

17 (3) (a) Covered expenses for the services or articles specified in this section do not include:

18 (i) home and office calls, except as specifically provided in subsection (2);

19 (ii) rental or purchase of durable medical equipment, except as specifically provided in subsection
20 (2);

21 (iii) the first \$20 of diagnostic x-ray and laboratory charges in each 14-day period;

22 (iv) oral surgery, except as specifically provided in subsection (2);

23 (v) that part of a charge for services or articles that exceeds the prevailing charge in the state
24 where the service is provided; or

25 (vi) care that is primarily for custodial or domiciliary purposes that would not qualify as eligible
26 services under medicare.

27 (b) Covered expenses for the services or articles specified in this section do not include charges
28 for:

29 (i) care or for any injury or disease arising out of an injury in the course of employment and subject
30 to a workers' compensation or similar law, for which benefits are payable under another policy of disability

- 1 insurance or medicare;
- 2 (ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or
- 3 congenital bodily defect to restore normal bodily functions;
- 4 (iii) travel other than transportation provided by a licensed ambulance service to the nearest facility
- 5 qualified to treat the condition, except as provided by subsection (2);
- 6 (iv) confinement in a private room to the extent that it is in excess of the institution's charge for
- 7 its most common semiprivate room, unless the private room is prescribed as medically necessary by a
- 8 physician;
- 9 (v) services or articles the provision of which is not within the scope of authorized practice of the
- 10 institution or individual rendering the services or articles;
- 11 (vi) room and board for a nonemergency admission on Friday or Saturday;
- 12 (vii) routine well baby care;
- 13 (viii) complications to a newborn, unless no other source of coverage is available;
- 14 (ix) reversal of sterilization;
- 15 (x) abortion, unless the life of the mother would be endangered if the fetus were carried to term;
- 16 (xi) weight modification or modification of the body to improve the mental or emotional well-being
- 17 of an insured;
- 18 (xii) artificial insemination or treatment for infertility; or
- 19 (xiii) breast augmentation or reduction."

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21 NEW SECTION. **Section 5. Effective date.** [This act] is effective on passage and approval.

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