HOUSE BILL NO. 621

INTRODUCED BY T. MCGILLVRAY, ARNTZEN, DUTTON, HIMMELBERGER, KERNS, LANGE, MACLAREN, MENDENHALL, SALES

A BILL FOR AN ACT ENTITLED: "AN ACT ~~REQUIRING EACH~~ ALLOWING A HEALTH INSURANCE ISSUER TO OFFER A LIMITED-BENEFIT CONTRACT FREE OF CERTAIN STATE-MANDATED HEALTH BENEFITS ~~AND TO OFFER~~ IN ADDITION TO THE REQUIRED HEALTH INSURANCE COVERAGE THAT INCLUDES STATE-MANDATED HEALTH BENEFITS FOR HEALTH CARE SERVICES RELATED TO A SPECIFIC ILLNESS, INJURY, OR CONDITION OF THE COVERED PERSON; PROVIDING EXCEPTIONS UNDER CERTAIN MANDATED BENEFIT LAWS; PROVIDING THAT ISSUING A LIMITED-BENEFIT CONTRACT IS NOT A DISCRIMINATORY PRACTICE; PROVIDING AN APPROPRIATION; AMENDING SECTIONS 33-22-101, 33-22-131, 33-22-132, 33-22-133, 33-22-134, 33-22-135, 33-22-301, 33-22-504, 33-22-701, 33-22-703, 33-22-704, 33-22-706, 33-22-1002, 33-30-102, 33-30-1001, 33-31-111, 40-5-816, AND 49-2-309, MCA; AND PROVIDING ~~A DELAYED~~ EFFECTIVE ~~DATE~~ DATES AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Definitions.** For the purposes of [sections 1 and 2], the following definitions apply:

(1) "Limited-benefit contract" means a policy, certificate, membership contract, or health care services agreement offered by a health insurance issuer that does not contain all state-mandated health benefits.

(2) "State-mandated health benefits" means coverage for health care services or benefits required by state law, excluding any health care service or benefit mandated by federal law, that requires the reimbursement of services related to a specific illness, injury, or condition of the covered person, including coverage under 33-22-131 through 33-22-135, 33-22-301, 33-22-504, Title 33, chapter 22, part 7, 33-22-1002, 33-22-1827, and 33-30-1001.

NEW SECTION. **Section 2. Plan with and plan without state-mandated benefits ~~required~~.** (1) A health insurance issuer shall offer at least ~~two types of health benefit plans, including~~ one plan providing a choice of deductibles or copayments with state-mandated health benefits and ~~one~~ MAY OFFER ONE OR MORE

limited-benefit ~~plan as provided in subsection (2)~~ PLANS.

~~(2) A health insurance issuer shall offer a health benefit plan in a limited-benefit contract that is not subject to all state-mandated health benefits and that does not contain standard provisions or rights required to be present in a health benefit plan pursuant to law or regulations unrelated to a specific illness, injury, or condition of the insured.~~

~~(3)~~(2) Each health insurance issuer that develops or offers a health benefit plan that is a limited-benefit contract shall specify on the face page of the policy and certificate, printed in 10-point or larger type, a statement that clearly indicates in substance the following:

"IMPORTANT NOTICE: This policy is a limited-benefit contract that has been established by [sections 1 and 2]. It does not contain all state-mandated health benefits found under Montana insurance laws. READ YOUR POLICY CAREFULLY."

~~(4) All health benefit plans and limited-benefit plans are subject to the following provisions as applicable under state and federal law:~~

~~(a) Any plan that covers physical illness generally must cover severe mental illness at a level that is no less favorable than that level provided for other physical illness generally.~~

~~(b) Any federal law regarding benefits, covered services, portability, or conversion rights applies.~~

~~(c) The provisions in Title 33, chapter 36, regarding network adequacy and quality assurance apply.~~

**Section 3.** Section 33-22-101, MCA, is amended to read:

**"33-22-101. Exceptions to scope.** (1) Subject to subsection (2), parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-140, 33-22-141, 33-22-142, [sections 1 and 2], 33-22-243, ~~and~~ 33-22-304, and 33-22-703, and part 19 of this chapter do not apply to or affect:

(a) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(b) any group or blanket policy;

(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract;

(d) reinsurance.

(2) (a) Sections 33-22-150~~,~~ and 33-22-151~~, and 33-22-301~~ apply to group or blanket policies.

(b) Except as provided in [section 2], 33-22-301 applies to group or blanket policies."

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

**"33-22-131. Coverage for treatment of inborn errors of metabolism.** (1) ~~Each~~ Except as provided in [section 2], each group or individual medical expense disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

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

(3) For purposes of this section:

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

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

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

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

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

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

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

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

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

**"33-22-132. Coverage for mammography examinations.** (1) ~~Each~~ Except as provided in [section 2], each group or individual medical expense, cancer, and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide minimum mammography examination coverage.

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

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

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

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

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

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

~~(5) A limited-benefit plan provided under [section 2] may exclude only the coverage mandated by state law, but is subject to the Women's Health and Cancer Rights Act of 1998, 42 U.S.C. 300gg-6 through 300gg-52.~~"

**Section 6.** Section 33-22-133, MCA, is amended to read:

**"33-22-133. Coverage for minimum hospital stay following childbirth.** (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) ~~Each~~ Except as provided in [section 2], each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by

cesarean section for a mother and newborn infant in a health care facility, as defined in 50-5-101.

(3) A decision to shorten the length of an inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health benefit plan, as defined in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider.

(5) A health benefit plan, as defined in 33-22-243, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.

(6) A limited-benefit plan provided under [section 2] may exclude only the coverage mandated by state law, but is subject to the Newborns' and Mothers' Health Protection Act of 1996, 42 U.S.C. 300gg-4."

**SECTION 7.** SECTION 33-22-134, MCA, IS AMENDED TO READ:

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

(2) A limited-benefit plan provided under [section 2] may exclude only the coverage mandated by state law but is subject to the Women's Health and Cancer Rights Act of 1998, 42 U.S.C. 300gg-6 through 300gg-52."

**SECTION 8.** SECTION 33-22-135, MCA, IS AMENDED TO READ:

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

(2) ~~Each~~ Except as provided in [section 2], each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for all stages of one reconstructive breast surgery on the nondiseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed.

(3) For the purposes of this section:

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

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

(4) ~~Benefits~~ Except as provided in [section 2], benefits for reconstructive breast surgery include but are not limited to the costs of prostheses and, under any contract providing outpatient x-ray or radiation therapy, benefits for outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer that must be included as a part of the outpatient x-ray or radiation therapy benefit.

(5) A limited-benefit plan provided under [section 2] may exclude only the coverage mandated by state law but is subject to the Women's Health and Cancer Rights Act of 1998, 42 U.S.C. 300gg-6 through 300gg-52."

**Section 9.** Section 33-22-301, MCA, is amended to read:

**"33-22-301. (Temporary) Coverage of newborn under disability policy.** (1) Except as provided in [section 2] and 33-22-262, each policy of disability insurance or certificate issued must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons. However, for newborn infants, there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) Except as provided in [section 2] and 33-22-262, a policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

**33-22-301. (Effective July 1, 2009) Coverage of newborn under disability policy.** (1) ~~Each~~ Except as provided in [section 2], each policy of disability insurance or certificate issued must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons. However, ~~that~~ for newborn infants, there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) ~~A~~ Except as provided in [section 2], a policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

**Section 10.** Section 33-22-504, MCA, is amended to read:

**"33-22-504. Newborn infant coverage.** (1) ~~A~~ Except as provided in [section 2], a group disability policy or certificate of insurance delivered or issued for delivery in this state may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of persons covered under the policy from and after the moment of birth.

(2) A policy or certificate subject to this section~~,~~ must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any person covered under

the policy.

(3) The coverage for newborn infants subject to this section must be the same as provided by the policy for other covered persons. However, for newborn infants, there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(4) This section does not apply to medicare supplement policies issued by reason of age.

(5) When a group disability policy or certificate issued under the policy provides for coverage or benefits for a resident of this state, the policy or certificate is considered delivered in this state within the meaning of this section regardless of whether the insurer issuing the policy or certificate is located in this state.

(6) The policy or certificate may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

**Section 11.** Section 33-22-701, MCA, is amended to read:

**"33-22-701. Scope of part -- purpose -- exception.** (1) Except as provided in [section 2] and 33-22-706, the provisions of this part apply to all group policies and certificates of accident and health insurance and group subscriber contracts for the care and treatment of mental illness, alcoholism, and drug addiction offered to Montana residents by insurers, health service corporations, and all employees' health and welfare funds that provide accident and health insurance benefits to residents of this state. It is the purpose of this part to preserve the rights of the consumer to have this coverage according to the consumer's medical and economic needs.

(2) A limited-benefit plan provided under [section 2] may exclude only the coverage in this part mandated by state law, but is subject to the Mental Health Parity Act of 1996, 42 U.S.C. 300gg-5."

**Section 12.** Section 33-22-703, MCA, is amended to read:

**"33-22-703. Coverage for mental illness, alcoholism, and drug addiction.** ~~A~~ Except as provided in [section 2], a group health plan or a health insurance issuer that provides group health insurance coverage shall provide for Montana residents covered by the plan at least the following level of benefits for the necessary care and treatment of mental illness, alcoholism, and drug addiction:

(1) under basic inpatient expense policies or contracts, inpatient hospital benefits and outpatient benefits

consisting of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(a) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(b) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

(c) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000; and

(d) costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the annual and lifetime limits in subsection (1)(c);

(2) under major medical policies or contracts, inpatient benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(a) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(b) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

(c) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, may be subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000;

(d) costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the annual and lifetime benefits in subsection (2)(c); and

(e) outpatient treatment for mental illness may be subject to a maximum yearly benefit of no less than $2,000, but this subsection (2)(e) does not apply to benefits for services furnished before September 30, 2001."

**Section 13.** Section 33-22-704, MCA, is amended to read:

**"33-22-704. Applicability.** Except as provided in [section 2] and 33-22-706, this part applies to policies, certificates, contracts, or any employees' health and welfare fund that provides accident and health insurance benefits~~,~~ established, delivered, issued for delivery, or renewed after September 30, 1987, but does not apply

to blanket, short-term travel, accident-only, limited or specified disease, individual conversion policies or contracts, or ~~to~~ policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental plans."

**Section 14.** Section 33-22-706, MCA, is amended to read:

**"33-22-706. (Temporary) Coverage for severe mental illness -- definition.** (1) Except as provided in [section 2] and 33-22-262(3) and subject to 33-22-262(4), a policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of severe mental illness, as defined in subsection (6), that is no less favorable than that level provided for other physical illness generally. Benefits for treatment of severe mental illness may be subject to managed care provisions contained in the policy or certificate.

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

(a) inpatient hospital services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication;

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

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

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

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

(i) individual and group health and disability insurance;

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

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation;

(v) health maintenance organizations; and

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

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

(i) blanket;

(ii) short-term travel;

(iii) ~~accident only~~ accident-only;

(iv) limited or specific disease;

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

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

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

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

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

**33-22-706. (Effective July 1, 2009) Coverage for severe mental illness -- definition.** (1) ~~A~~ Except as provided in [section 2], a policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of severe mental illness, as defined in subsection (6), that is no less favorable than that level provided for other physical illness generally. Benefits for treatment of severe mental illness may be subject to managed care provisions contained in the policy or certificate.

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

(a) inpatient hospital services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication;

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

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

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

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

(i) individual and group health and disability insurance;

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

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation;

(v) health maintenance organizations; and

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

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

(i) blanket;

(ii) short-term travel;

(iii) ~~accident only~~ accident-only;

(iv) limited or specific disease;

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

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

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

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

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism."

**Section 15.** Section 33-22-1002, MCA, is amended to read:

**"33-22-1002. Availability of coverage for home health care.** ~~Insurers~~ Except as provided in [section 2], insurers and health service corporations transacting health insurance business in this state shall make available, under group insurance policies or certificates and under group hospital and medical service plan contracts, benefits for home health care. Applicants for a group policy, certificate, or contract may select any level of benefits that may be offered by the insurer or service plan corporation."

**Section 16.** Section 33-30-102, MCA, is amended to read:

**"33-30-102. Application of this chapter -- construction of other related laws.** (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, except as provided under [section 2], other chapters and provisions of this title apply to health service corporations as follows: 33-2-1212; 33-3-307; 33-3-308; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 2, part 19; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict, the provisions of this chapter prevail."

**Section 17.** Section 33-30-1001, MCA, is amended to read:

**"33-30-1001. (Temporary) Newborn infants covered by insurance by health service corporation.** Except as provided in [section 2] and 33-22-262, a disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each policy must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity

corporation within 31 days of the birth in order to have the coverage extend beyond 31 days. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

**33-30-1001. (Effective July 1, 2009) Newborn infants covered by insurance by health service corporation.** ~~A~~ Except as provided in [section 2], a disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each policy must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

**Section 18.** Section 33-31-111, MCA, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Section 19.** Section 40-5-816, MCA, is amended to read:

**"40-5-816. Newborn children.** ~~A~~ Except as provided in [section 2], a health benefit plan must provide the coverage required by 33-22-301 to a newborn child covered by this part."

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

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

(2) This section does not apply to:

(a) any insurance policy, plan, or coverage or to any pension or retirement plan, program, or coverage in effect prior to October 1, 1985; or

(b) a limited-benefit contract as provided in [sections 1 and 2].

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

NEW SECTION. **SECTION 21. APPROPRIATION.** THERE IS APPROPRIATED FROM THE STATE GENERAL FUND TO THE STATE AUDITOR'S OFFICE $5,000 FOR THE BIENNIUM BEGINNING JULY 1, 2007. THE APPROPRIATION MUST BE USED TO CONDUCT A REVIEW OF THE NUMBER AND TYPES OF LIMITED-BENEFIT PLANS OFFERED UNDER [SECTION 2] AND THE NUMBER OF PEOPLE COVERED UNDER LIMITED-BENEFIT PLANS DURING THE BIENNIUM. THE STATE AUDITOR'S OFFICE SHALL PROVIDE THE INFORMATION TO THE 61ST LEGISLATURE, AS PROVIDED IN 5-11-210.

NEW SECTION. **Section 22. Codification instruction.** [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [sections 1 and 2].

NEW SECTION. **Section 23. Effective date -- applicability.** ~~[This act]~~ (1) EXCEPT AS PROVIDED IN SUBSECTION (2), [THIS ACT] is effective January 1, 2008, and applies to each health insurance issuer offering a policy, contract, plan, or certificate issued or renewed on or after that date.

(2) [SECTION 21 AND THIS SECTION] ARE EFFECTIVE JULY 1, 2007.

- END -