HOUSE BILL NO. 142

INTRODUCED BY L. BISHOP

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING PARITY BETWEEN MENTAL HEALTH AND PHYSICAL HEALTH INSURANCE COVERAGE IN GROUP, INDIVIDUAL, HEALTH MAINTENANCE ORGANIZATION, AND MULTIPLE EMPLOYER WELFARE ARRANGEMENT PLANS AND POLICIES, INCLUDING STATE, LOCAL GOVERNMENT, AND MONTANA STATE UNIVERSITY PLANS AND POLICIES; REVISING DEFINITIONS; EXTENDING RULEMAKING AUTHORITY; REPEALING LIMITED POLICY APPLICATIONS; AMENDING SECTIONS 2-18-704, 33-22-701, 33-22-702, 33-22-703, 33-22-705, 33-31-111, AND 33-35-306, MCA; REPEALING SECTIONS 33-22-704 AND 33-22-706, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

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

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

(a) the member of a group who retires from active service under the appropriate retirement provisions of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19, chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered employment to remain a member of the group until the member becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, unless the member is a participant in another group plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost;

(b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible for equivalent insurance coverage as provided in subsection (1)(a);

(c) the surviving children of a member to remain members of the group as long as they are eligible for retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

(2) An insurance contract or plan issued under this part must contain the provisions of subsection (1) for remaining a member of the group and also must permit:

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

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

(c) continued membership in the group by anyone eligible under the provisions of this section, notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

(3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a member of the state's group plan until the legislator becomes eligible for medicare under the federal Health Insurance for the Aged Act if the legislator:

(i) terminates service in the legislature and is a vested member of a state retirement system provided by law; and

(ii) notifies the department of administration in writing within 90 days of the end of the legislator's legislative term.

(b) A former legislator may not remain a member of the group plan under the provisions of subsection (3)(a) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

(c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and subsequently terminates membership may not rejoin the group plan unless the person again serves as a legislator.

(4) (a) A state insurance contract or plan must contain provisions that permit continued membership in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's choice to continue membership in the group plan.

(b) A former judge may not remain a member of the group plan under the provisions of this subsection (4) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or

(iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act.

(c) A judge who remains a member of the group under the provisions of this subsection (4) and subsequently terminates membership may not rejoin the group plan unless the person again serves in a position covered by the state's group plan.

(5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the full premium for coverage and for that of the person's covered dependents.

(6) An insurance contract or plan issued under this part that provides for the dispensing of prescription drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

(a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty to the member; and

(b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

(7) An insurance contract or plan issued under this part must include coverage for:

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

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

(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. (See compiler's comments for contingent termination of certain text.)

(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."

Section 2. Section 33-22-701, MCA, is amended to read:

"33-22-701. ~~Scope~~ Short title -- applicability -- scope of part ~~-- purpose~~ -- exception. (1) This part may be cited as the "Montana Mental Health Parity Act".

(2) The ~~Except as provided in 33-22-706, the~~ provisions of this part apply to all ~~group~~ policies and certificates of ~~accident~~ individual and group health insurance and group ~~subscriber contracts for the care and treatment of mental illness, alcoholism, and drug addiction~~ health plans offered to, renewed for, or issued to Montana residents by ~~insurers, health service corporations, and all employees' health and welfare funds that provide accident and~~ any health insurance issuer ~~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~~.

(3) This part does not apply to coverage described as excepted benefits under 33-22-140."

Section 3. Section 33-22-702, MCA, is amended to read:

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

~~(1) "Chemical dependency treatment center" means a treatment facility that:~~

~~(a) provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment plan approved and monitored by a physician or addiction counselor licensed by the state; and~~

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

~~(2)~~(1) "Inpatient benefits" are as set forth in 33-22-705.

~~(3)~~(2) "Mental health treatment center" means a treatment facility organized to provide care and

treatment for mental illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by ~~an interdisciplinary team, including a licensed physician, psychiatric social worker, and psychologist,~~ a qualified health care provider and a treatment facility that is~~:~~

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

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

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

~~(4)~~(3) (a) "Mental illness" means a clinically significant ~~behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:~~

~~(i) present distress or a painful symptom;~~

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

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

~~(b) Mental illness must be considered as a manifestation of a behavioral,~~ disturbance in an individual's cognition, emotional regulation, or behavior that reflects a psychological~~,~~ or biological dysfunction in the underlying mental functioning of a person, causing distress or disability in social, occupational, or other important activities.

(b) Mental illness includes:

(i) any mental health condition or disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Diseases or that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders;

(ii) autism;

(iii) a diagnosis of any of the following for a child with autism who is 18 years of age or younger, for whom coverage also must comply with 33-22-515(3) through (5):

(A) autistic disorder;

(B) Asperger's disorder; or

(C) pervasive developmental disorder not otherwise specified.

(c) Mental illness does not include:

(i) a developmental disorder, except autism; or

(ii) a speech disorder~~;~~

~~(iii) a psychoactive substance use disorder;~~

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

~~(v) an impulse control disorder, except for intermittent explosive disorder and trichotillomania; or~~

~~(vi) a severe mental illness as provided in 33-22-706~~.

~~(5)~~(4) "Outpatient benefits" are as set forth in 33-22-705.

(5) "Qualified health care provider" includes a physician, psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, and licensed addiction counselor.

(6) (a) "Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using alcohol, drugs, or both despite significant substance abuse-related problems.

(b) Substance use disorder includes any condition or disorder that falls under any of the diagnostic categories listed in the mental disorders section of the current edition of the International Classification of Diseases or that is listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Substance use disorder includes but is not limited to impaired control over substance use, social impairment, risky use of substances, tolerance of substances, and withdrawal symptoms when blood or tissue concentrations of a substance decline.

(c) Substance use disorder does not include caffeine or nicotine abuse.

(7) "Substance use disorder treatment center" means a treatment facility that:

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

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

Section 4. Section 33-22-703, MCA, is amended to read:

"33-22-703. Coverage for mental illness~~, alcoholism, and drug addiction~~ substance use disorders -- definitions. (1) A ~~group health plan or a~~ health insurance issuer that ~~provides~~ issues, modifies, or renews group or individual health insurance coverage or a group health plan 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~~ substance use disorders at a level of benefits that is no less favorable than that level provided for physical illness generally.

(2) Benefits for the treatment of mental illness and substance use disorder include but are not limited to:

~~(1)~~(a) ~~under basic inpatient expense policies or contracts,~~ inpatient ~~hospital~~ benefits; ~~and~~

(b) 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~~

(c) acute and subacute partial hospitalization through a program that complies with the standards for ~~a~~ partial hospitalization ~~program that are published by the association for ambulatory behavioral healthcare if the program is operated by a hospital~~ programs established by the department of public health and human services;

~~(c)~~(d) intensive outpatient therapy; ~~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)~~(e) ~~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)~~; and

(f) all medically necessary prescription drugs.

(3) For the purposes of this section, the following definitions apply:

(a) "No less favorable" means that the insurer may not apply quantitative treatment limitations or nonquantitative treatment limitations for mental illness or substance abuse that are more restrictive than those applied to physical illness.

(b) "Nonquantitative treatment limitations" are nonnumerical limitations on access to or on the scope of treatment, including but not limited to:

(i) medical management standards that limit or exclude benefits, such as medical necessity review, preauthorization requirements, or fail-first protocols;

(ii) formulary design or other methods of limiting access to prescription drugs;

(iii) limitations on provider access, including network design, lack of network adequacy, and access to out-of-network providers;

(iv) standards for provider admission to participate in a network, including reimbursement rates; and

(v) methods for determining usual, customary, and reasonable charges.

(c) "Quantitative treatment limitations" are numerical and include durational or frequency limitations or financial limitations that encompass but are not limited to:

(i) cost-sharing, including coinsurance, copayments, deductibles, and maximum out-of-pocket limits; and

(ii) visit limits, day limits, and waiting periods.

~~(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 association for ambulatory behavioral healthcare 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 5. Section 33-22-705, MCA, is amended to read:

"33-22-705. Inpatient and outpatient benefits. (1) "Inpatient benefits" are benefits payable for charges made by a hospital or freestanding inpatient facility for the necessary care and treatment of mental illness, ~~alcoholism, or drug addiction~~ substance use disorder, or co-occurring mental illness with substance use disorder furnished to a covered person while confined as an inpatient ~~and, with respect to major medical policies or contracts,~~. Inpatient benefits also ~~includes~~ include those benefits payable for charges made by a ~~physician~~ qualified health care provider for the necessary care and treatment of mental illness, ~~alcoholism, or drug addiction~~ substance use disorder, or co-occurring mental illness and substance use disorder furnished to a covered person while confined as an inpatient. Care and treatment of ~~alcoholism or drug addiction~~ substance use disorder in a freestanding inpatient facility must be in a ~~chemical dependency~~ substance use disorder treatment center that is approved by the department of public health and human services under 53-24-208. Inpatient benefits include payment for medically monitored and medically managed intensive inpatient services and clinically managed high-intensity residential services.

(2) "Outpatient benefits" are benefits payable for:

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

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

(c) reasonable charges made by a mental health or ~~chemical dependency~~ substance use disorder treatment center for the necessary care and treatment of a covered person provided in the treatment center while not confined as an inpatient. The ~~chemical dependency~~ substance use disorder treatment center must be approved by the department of public health and human services under 53-24-208.

(d) reasonable charges for services rendered by a ~~licensed psychiatrist, psychologist, licensed professional counselor, licensed social worker, or addiction counselor licensed by the department of labor and industry under Title 37, chapter 35~~ qualified health care provider, hospital, mental health treatment center, or substance use disorder treatment center in an acute or subacute partial hospitalization or intensive outpatient treatment setting."

NEW SECTION. **Section 6. Rulemaking.** The commissioner may adopt rules to implement the provisions of 33-22-701, 33-22-703, 33-22-705, 33-31-111, and 33-35-306.

Section 7. 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, 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) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 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, ~~33-22-706~~ Title 33, chapter 22, part 7, Title 33, chapter 32[, and Title 33, chapter 40, part 1,] apply to health maintenance organizations. (Bracketed language in (7) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

Section 8. Section 33-35-306, MCA, is amended to read:

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

(a) 33-1-111;

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

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

(d) 33-3-308;

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

(f) Title 33, chapter 19;

(g) 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;

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

(i) Title 33, chapter 22, part 7; and

~~(i)~~(j) Title 33, chapter 40, part 1.

(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. (Subsection ~~(1)(i)~~ (1)(j) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

NEW SECTION. **Section 9. Repealer.** The following sections of the Montana Code Annotated are repealed:

33-22-704. Applicability.

33-22-706. Coverage for severe mental illness -- definition.

NEW SECTION. **Section 10. Codification instruction.** [Section 6] is intended to be codified as an integral part of Title 33, chapter 22, part 7, and the provisions of Title 33, chapter 22, part 7, apply to [section 6].

NEW SECTION. **Section 11. Effective date -- applicability.** [This act] is effective on passage and approval and applies to policies and plans offered or sold on or after [the effective date of this act].

- END -