

HOUSE BILL NO. 359

INTRODUCED BY E. DUTTON, BECKER, BOGGIO, BUTCHER, EVERETT, FRANKLIN, HEINERT,
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A BILL FOR AN ACT ENTITLED: "AN ACT ~~REQUIRING~~ ALLOWING CLINICAL LABORATORY TESTING TO
BE CONDUCTED AT AN INDIVIDUAL'S REQUEST; AND AMENDING SECTIONS 33-22-303, 33-22-512,
33-22-1521, 33-30-1014, AND 33-31-102, MCA."

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

NEW SECTION. Section 1. Laboratory testing at individual's request -- exceptions -- insurance

exemption. (1) Except as provided in subsection (2), ~~health care providers and~~ clinical laboratories THAT
DIRECTLY OR INDIRECTLY ACCEPT PAYMENTS FROM MEDICARE, MEDICAID, THE CHILDREN'S HEALTH INSURANCE PROGRAM,
OR WORKERS' COMPENSATION shall provide clinical laboratory tests, PURSUANT TO SUBSECTION (3), to an individual
without a request from a physician or other practitioner of the healing arts licensed pursuant to Title 37.

(2) ~~(A) Health care providers and clinical~~ CLINICAL laboratories may not provide a test that involves an
invasive procedure that may pose a serious medical risk to the individual except at the request of a physician or
other practitioner of the healing arts licensed pursuant to Title 37.

(B) A CLINICAL LABORATORY MAY NOT BE REQUIRED TO PROVIDE A TEST IT DOES NOT OFFER IN THE NORMAL
COURSE OF BUSINESS.

(3) Services provided at the individual's request:

(A) MUST BE ON A LIST OF APPROVED TESTS ESTABLISHED BY THE DEPARTMENT AND DEVELOPED IN
CONSULTATION WITH MONTANA REPRESENTATIVES OF THE AMERICAN SOCIETY FOR CLINICAL LABORATORY SCIENCE AND
THE MONTANA MEDICAL ASSOCIATION;

~~(a)(B)~~ must be provided for the lowest rate charged by the health care provider or laboratory providing
the service if the individual is paying cash BY A NONPROFIT HOSPITAL AT NO MORE THAN 120% OF THE RATE PAID BY
MEDICARE FOR THE SERVICE AND FOR COLLECTION OF A SPECIMEN FOR TESTING AND MUST BE PAID FOR in advance;

~~(b)(C)~~ may be exempt from coverage by a health care insurer if the insurer has not approved the service;

~~(c)(D)~~ may not be applied toward the individual's insurance deductible if the health care insurer has not

1 approved the service.

2 (4) LIABILITY UNDER THIS SECTION IS LIMITED TO THE TEST ITSELF. THERE IS NO LIABILITY ON THE PART OF AND
 3 NO CAUSE OF ACTION MAY ARISE AGAINST A CLINICAL LABORATORY FOR THE WAY IN WHICH TEST RESULTS MAY BE
 4 INTERPRETED BY A PATIENT.

5 ~~(4)~~(5) As used in this section, the following definitions apply:

6 (a) "Clinical laboratory" or "laboratory" means any facility or office in which clinical laboratory tests are
 7 performed.

8 (b) "Clinical laboratory test" or "laboratory test" means:

9 (i) a microbiological, serological, chemical, hematological, radiobioassay, cytological, biophysical,
 10 immunological, cytogenetical, or other examination that is performed on material derived from the human body;
 11 or

12 (ii) any other test or procedure that is conducted by a laboratory or facility and that provides information
 13 for the assessment of a medical condition or for the diagnosis, prevention, or treatment of a disease.

14 ~~(c) "Health care provider" means any person, corporation, or facility licensed by this state to provide~~
 15 ~~health care, including but not limited to a physician, osteopath, dentist, nurse, or health care facility as defined~~
 16 ~~in 50-5-101.~~

17 (C) "INDIVIDUAL" MEANS A PERSON 18 YEARS OF AGE OR OLDER.

18

19 **Section 2.** Section 33-22-303, MCA, is amended to read:

20 **"33-22-303. Coverage for well-child care.** (1) Each medical expense policy of disability insurance or
 21 certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this
 22 state by a disability insurer and that provides coverage for a family member of the insured or subscriber must
 23 provide coverage for well-child care for children from the moment of birth through 2 years of age. Benefits
 24 provided under this coverage are exempt from any deductible provision that may be in force in the policy or
 25 certificate issued under the policy.

26 (2) Coverage for well-child care under subsection (1) must include:

27 (a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory
 28 tests, except as provided in [section 1], according to the schedule of visits adopted under the early and periodic
 29 screening, diagnosis, and treatment services program provided for in 53-6-101; and

30 (b) routine immunizations according to the schedule for immunizations recommended by the

1 immunization practices advisory committee of the U.S. department of health and human services.

2 (3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided
3 at each visit cited in this section.

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

6 (5) For purposes of this section:

7 (a) "well-child care" means the services described in subsection (2) and delivered by a physician or a
8 health care professional supervised by a physician; and

9 (b) "developmental assessment" and "anticipatory guidance" mean the services described in the
10 Guidelines for Health Supervision II, published by the American academy of pediatrics.

11 (6) When a policy of disability insurance or a certificate issued under the policy provides coverage or
12 benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section,
13 whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."
14

15 **Section 3.** Section 33-22-512, MCA, is amended to read:

16 **"33-22-512. Coverage for well-child care.** (1) Each group disability policy or certificate of insurance
17 that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that
18 provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for
19 children from the moment of birth through 2 years of age. Benefits provided under this coverage are exempt from
20 any deductible provision that may be in force in the policy or certificate issued under the policy.

21 (2) Coverage for well-child care under subsection (1) must include:

22 (a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory
23 tests, except as provided in [section 1], according to the schedule of visits adopted under the early and periodic
24 screening, diagnosis, and treatment services program provided for in 53-6-101; and

25 (b) routine immunizations according to the schedule for immunizations recommended by the
26 immunization practices advisory committee of the U.S. department of health and human services.

27 (3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided
28 at each visit cited in this section.

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

1 (5) For purposes of this section:

2 (a) "well-child care" means the services described in subsection (2) and delivered by a physician or a
3 health care professional supervised by a physician; and

4 (b) "developmental assessment" and "anticipatory guidance" mean the services described in the
5 Guidelines for Health Supervision II, published by the American academy of pediatrics.

6 (6) When a group disability policy or certificate of insurance issued under the policy provides coverage
7 or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this
8 section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this
9 state."

10

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

12 **"33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as
13 an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting 33-22-701
14 through 33-22-705), and 30, and other laws of this state, whether or not the policy is issued in this state, and
15 meets or exceeds the following minimum standards:

16 (1) (a) The minimum benefits for an insured must, subject to the other provisions of this section, be equal
17 to at least 50% of the covered expenses required by this section in excess of an annual deductible that does not
18 exceed \$1,000 per person. The coverage must include a limitation of \$5,000 per person on the total annual
19 out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime
20 benefit, but the maximums may not be less than \$100,000.

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

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

27 (d) The board may authorize other association plans, including managed care plans as defined in
28 33-36-103.

29 (2) Covered expenses for plans offered under subsections (1)(a) and (1)(b) must be for the following
30 medically necessary services and articles when prescribed by a physician or other licensed health care

- 1 professional and when designated in the contract:
- 2 (a) hospital services;
- 3 (b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than
4 dental;
- 5 (c) use of radium or other radioactive materials;
- 6 (d) oxygen;
- 7 (e) anesthetics;
- 8 (f) diagnostic x-rays and laboratory tests, except as specifically provided in section 1 and subsection
9 (3) of this section;
- 10 (g) services of a physical therapist;
- 11 (h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the
12 condition;
- 13 (i) oral surgery for the gums and tissues of the mouth when not performed in connection with the
14 extraction or repair of teeth or in connection with TMJ;
- 15 (j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has
16 been met at the rate of 50%, up to a maximum of \$1,000;
- 17 (k) prosthetics, other than dental;
- 18 (l) services of a licensed home health agency, up to a maximum of 180 visits per year;
- 19 (m) drugs requiring a physician's prescription that are approved for use in human beings in the manner
20 prescribed by the United States food and drug administration, covered at 50% of the expense, up to an annual
21 maximum of \$2,000;
- 22 (n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs,
23 liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of
24 \$150,000, with an additional benefit not to exceed \$10,000 for expenses associated with the donor;
- 25 (o) pregnancy, including complications of pregnancy;
- 26 (p) newborn infant coverage, as required by 33-22-301;
- 27 (q) sterilization;
- 28 (r) immunizations;
- 29 (s) outpatient rehabilitation therapy;
- 30 (t) foot care for diabetics;

- 1 (u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60
2 days per year;
- 3 (v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to
4 treat the patients medical condition when approved in advance by the insurer; and
- 5 (w) coverage for severe mental illness as required in 33-22-706.
- 6 (3) (a) Covered expenses for the services or articles specified in this section do not include:
- 7 (i) home and office calls, except as specifically provided in subsection (2);
- 8 (ii) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);
- 9 (iii) the first \$20 of diagnostic x-ray and laboratory charges in each 14-day period or laboratory tests
10 conducted pursuant to [section 1];
- 11 (iv) oral surgery, except as specifically provided in subsection (2);
- 12 (v) that part of a charge for services or articles that exceeds the prevailing charge in the state where the
13 service is provided; or
- 14 (vi) care that is primarily for custodial or domiciliary purposes that would not qualify as eligible services
15 under medicare.
- 16 (b) Covered expenses for the services or articles specified in this section do not include charges for:
- 17 (i) care or for any injury or disease arising out of an injury in the course of employment and subject to
18 a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance
19 or medicare;
- 20 (ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or
21 congenital bodily defect to restore normal bodily functions;
- 22 (iii) travel other than transportation provided by a licensed ambulance service to the nearest facility
23 qualified to treat the condition, except as provided by subsection (2);
- 24 (iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most
25 common semiprivate room, unless the private room is prescribed as medically necessary by a physician;
- 26 (v) services or articles the provision of which is not within the scope of authorized practice of the
27 institution or individual rendering the services or articles;
- 28 (vi) room and board for a nonemergency admission on Friday or Saturday;
- 29 (vii) routine well baby care;
- 30 (viii) complications to a newborn, unless no other source of coverage is available;

- 1 (ix) reversal of sterilization;
- 2 (x) abortion, unless the life of the mother would be endangered if the fetus were carried to term;
- 3 (xi) weight modification or modification of the body to improve the mental or emotional well-being of an
4 insured;
- 5 (xii) artificial insemination or treatment for infertility; or
- 6 (xiii) breast augmentation or reduction."

7

8 **Section 5.** Section 33-30-1014, MCA, is amended to read:

9 **"33-30-1014. Coverage for well-child care.** (1) Each disability insurance plan or group disability
10 insurance plan that is delivered, issued for delivery, renewed, extended, or modified in this state by a health
11 service corporation and that provides coverage for a family member of the insured or subscriber must provide
12 coverage for well-child care for children from the moment of birth through 2 years of age. Benefits provided under
13 this coverage are exempt from any deductible provision that may be in force in the plan.

14 (2) Coverage for well-child care under subsection (1) must include:

15 (a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory
16 tests, except as provided in [section 1], according to the schedule of visits adopted under the early and periodic
17 screening, diagnosis, and treatment services program provided for in 53-6-101; and

18 (b) routine immunizations according to the schedule for immunizations recommended by the
19 immunization practices advisory committee of the U.S. department of health and human services.

20 (3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided
21 at each visit cited in this section.

22 (4) This section does not apply to disability income, specified disease, medicare supplement, or hospital
23 indemnity policies.

24 (5) For purposes of this section:

25 (a) "well-child care" means the services described in subsection (2) and delivered at the intervals
26 required in that subsection by a physician or a health care professional supervised by a physician; and

27 (b) "developmental assessment" and "anticipatory guidance" mean the services described in the
28 Guidelines for Health Supervision II, published by the American academy of pediatrics.

29 (6) When a disability insurance plan or group disability insurance plan issued by a health service
30 corporation provides coverage or benefits to a resident of this state, it is considered to be delivered in this state

1 within the meaning of this section, whether the health service corporation that issued or delivered the policy or
2 certificate is located inside or outside of this state."

3

4 **Section 6.** Section 33-31-102, MCA, is amended to read:

5 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the following
6 definitions apply:

7 (1) "Affiliation period" means a period that, under the terms of the health insurance coverage offered by
8 a health maintenance organization, must expire before the health insurance coverage becomes effective.

9 (2) "Basic health care services" means:

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

11 (b) inpatient hospital and provider care;

12 (c) outpatient medical services;

13 (d) medical treatment and referral services;

14 (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to
15 33-31-301(3)(e);

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

17 (g) diagnostic laboratory tests, except as provided in [section 1], and diagnostic and therapeutic
18 radiologic services;

19 (h) preventive health services, including:

20 (i) immunizations;

21 (ii) well-child care from birth;

22 (iii) periodic health evaluations for adults;

23 (iv) voluntary family planning services;

24 (v) infertility services; and

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

27 (i) minimum mammography examination, as defined in 33-22-132;

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

30 (k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have

1 the meanings provided for in 33-22-131.

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

3 (4) "Enrollee" means a person:

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

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

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

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

10 (6) "Health care services" means:

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

12 (b) the services included in hospitalizing a person;

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

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

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

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

22 (9) "Insurance producer" means an individual, partnership, or corporation appointed or authorized by
23 a health maintenance organization to solicit applications for health care services agreements on its behalf.

24 (10) "Person" means:

25 (a) an individual;

26 (b) a group of individuals;

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

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

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

30 (f) an institution of a governmental unit of any state licensed by that state to provide health care, including

1 but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

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

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

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

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

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

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

20

21 **NEW SECTION. Section 7. Codification instruction.** [Section 1] is intended to be codified as an
22 integral part of Title 50, chapter 4, and the provisions of Title 50 apply to [section 1].

23

- END -