AN ACT REQUIRING HEALTH INSURERS TO DISCLOSE INFORMATION ABOUT COVERED BENEFITS FOR CANCER SCREENING; AMENDING SECTIONS 2-18-704, 33-22-244, 33-22-262, 33-22-521, 33-31-102, AND 33-31-301, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE.

WHEREAS, early detection of cancer can save lives and improve and increase treatment options for patients; and

WHEREAS, screening tests for cancer are the main tool for early detection of cancer; and

WHEREAS, health insurers may not routinely provide information on the coverage provided for cancer screenings; and

WHEREAS, state law requires health insurers to provide a summary of benefits offered to consumers; and

WHEREAS, because of the importance of early detection, consumers deserve and will benefit from information about the types of cancer screenings that a policy covers.

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, as amended, 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, 42 U.S.C. 1395, as amended, 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, 42 U.S.C. 1395, as amended.

(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 treatment of inborn errors of metabolism, as provided for in 33-22-131.

(8) An insurance contract or plan issued under this part must include substantially equivalent or greater coverage for outpatient self-management training and education for the treatment of diabetes and certain diabetic equipment and supplies as provided in 33-22-129.

(9) 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."

Section 2. Section 33-22-244, MCA, is amended to read:

"33-22-244. Disclosure standards -- individual policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

~~(b)~~(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

~~(c)~~(c) a statement of the maximum lifetime benefit available under the policy;

~~(d)~~(d) a statement of the estimated periodic premium to be paid by the insured;

~~(e)~~(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

~~(f)~~(f) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer; and

~~(g)~~(g) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(5) Prior to issuance of an individual disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a potential applicant. The informational materials are not subject to filing with and approval of the insurance commissioner."

Section 3. Section 33-22-262, MCA, is amended to read:

"33-22-262. (Temporary) Limited coverage individual health benefit plan or managed care plan -- demonstration project -- criteria -- rulemaking. (1) The commissioner of insurance may approve a 12-month demonstration project that allows a health insurance issuer to offer a limited coverage individual health benefit plan or managed care plan. The criteria for approval of a 12-month demonstration project include but are not limited to the following:

(a) the plan must include significant outpatient services and may not consist of inpatient benefits only;

(b) the plan may be offered only to residents of Montana who have been uninsured for 90 days or longer, except that at the discretion of the health insurance issuer, the plan may be offered to residents of Montana if the applicant:

(i) lost eligibility for a health plan because of age; or

(ii) lost coverage under a federally funded health insurance program, such as medicare, medicaid, or the Montana children's health insurance program, because of age or failure to meet financial guidelines; and

(c) the commissioner may adopt rules that describe additional criteria to be used to determine approval of demonstration projects. Additional criteria must relate to the purpose as stated in 33-22-261(2).

(2) The health benefit plan or managed care plan must specify the health services that are included and must specifically list the health services that will be limited or not be covered from the partial list of state-required coverage in subsection (3). The limitations and exclusions of the plan must be prominently displayed on the application and on the outline of coverage required by 33-22-244.

(3) Subject to subsection (4), if specifically listed as a limitation or an exclusion of coverage in the proposal, a demonstration project may limit or exclude the following health services from its health benefit plan or managed care plan:

(a) coverage of a newborn, as provided in 33-22-301, 33-30-1001, and ~~33-31-301(3)(e)~~ 33-31-301(3)(e), which may be subject only to the same extent of the limitations and exclusions contained in the parent's policy;

(b) coverage for severe mental illness, as provided in 33-22-706;

(c) coverage for mental health services, as provided in ~~33-31-301(3)(g)(i)~~ 33-31-301(3)(g)(i);

(d) benefits for emergency services, as provided in 33-36-201 and 33-36-205;

(e) coverage for certain basic health care services described in 33-31-102(2)(b) and (2)(h)(v);

(f) services provided by a specific category of licensed health care practitioner to be provided to the covered person for a health-related condition in a health benefit plan or managed care plan, including services

described in 33-22-125 and 33-30-1017;

(g) coverage for diabetic education, treatment, services, and supplies, as provided in 33-22-129; or

(h) coverage for treatment of inborn errors of metabolism, as provided in 33-22-131.

(4) All health benefit plan and managed care plan demonstration projects are subject to the following provisions:

(a) the requirement that any plan that covers physical illness generally must cover severe mental illness in a way that is no less favorable than that level provided for other physical illness generally as required by federal law;

(b) the prohibition against discrimination in 49-2-309;

(c) except as provided in subsection (3)(d), the provisions in Title 33, chapter 36, regarding network adequacy and quality assurance; and

(d) all other applicable provisions of Title 33, except those listed in subsection (3).

(5) Upon a renewal request and approval by the insurance commissioner, a demonstration project may be renewed for additional 12-month increments for a maximum total of 5 years. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)"

Section 4. Section 33-22-521, MCA, is amended to read:

"33-22-521. Disclosure standards -- group policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

~~(b)~~(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

~~(c)~~(c) a statement of the maximum lifetime benefit available under the policy;

~~(d)~~(d) a statement of the estimated periodic premium to be paid by the insured;

~~(e)~~(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

~~(f)~~(f) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer; and

~~(g)~~(g) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(6) An outline of coverage must also be sent to an employee when an employee is sent a certificate of insurance.

(7) Prior to issuance of a group disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a prospective applicant. The informational materials are not subject to filing with and approval of the insurance commissioner."

Section 5. Section 33-31-102, MCA, is amended to read:

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

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

(2) "Basic health care services" means:

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

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

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

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

(g) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(h) preventive health services, including:

(i) immunizations;

(ii) well-child care from birth;

(iii) periodic health evaluations for adults;

(iv) voluntary family planning services;

(v) infertility services; and

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

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

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

(k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have the meanings provided for in 33-22-131.

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

(4) "Enrollee" means a person:

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

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

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

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

(6) "Health care services" means:

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

(b) the services included in hospitalizing a person;

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

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

(7) "Health care services agreement" means an agreement for health care services between a health

maintenance organization and an enrollee.

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

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

(10) "Person" means:

(a) an individual;

(b) a group of individuals;

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

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

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

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

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

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

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

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

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

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

Section 6. Section 33-31-301, MCA, is amended to read:

"33-31-301. (Temporary) Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with 33-1-501.

(3) An evidence of coverage issued or delivered to a person residing in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be

stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

~~(d)~~(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

~~(e)~~(e) except as provided in 33-22-262, a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

~~(f)~~(f) a provision providing coverage as required in 33-22-133;

~~(g)~~(g) except as provided in 33-22-262, a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent

treatment or services;

(iv) the provisions of this subsection ~~(3)(g)~~ (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

~~(h)~~(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

~~(i)~~(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

~~(j)~~(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner in accordance with 33-1-501 and issued to the enrollee.

(5) (a) Except as provided in 33-22-262, a health maintenance organization shall provide the same coverage for newborn infants, required by subsection ~~(3)(e)~~ (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) Except as provided in 33-22-262, a health maintenance organization may not issue or amend an

evidence of coverage 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 enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) The provisions of 33-1-501 govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(8) Prior to issuance of an evidence of coverage, written informational materials describing the contract's cancer screening coverages must be provided to a prospective applicant. The informational materials are not subject to filing with and approval of the insurance commissioner. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-31-301. (Effective July 1, 2009) Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with 33-1-501.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

~~(d)~~(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

~~(e)~~(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

~~(f)~~(f) a provision providing coverage as required in 33-22-133;

~~(g)~~(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection ~~(3)~~(g) (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

~~(h)~~(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

~~(i)~~(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

~~(j)~~(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner in accordance with 33-1-501 and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection ~~(3)(e)~~ (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage 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 enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) The provisions of 33-1-501 govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(8) Prior to issuance of evidence of coverage, written informational materials describing the contract's cancer screening coverages must be provided to a potential applicant. The informational materials are not subject to filing with and approval of the insurance commissioner."

Section 7. Effective date. [This act] is effective January 1, 2008.

- END -

I hereby certify that the within bill,
SB 0387, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day
of _____, 2019.

Speaker of the House

Signed this _____ day
of _____, 2019.

SENATE BILL NO. 387

INTRODUCED BY SQUIRES, HENRY

AN ACT REQUIRING HEALTH INSURERS TO DISCLOSE INFORMATION ABOUT COVERED BENEFITS FOR CANCER SCREENING; AMENDING SECTIONS 2-18-704, 33-22-244, 33-22-262, 33-22-521, 33-31-102, AND 33-31-301, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE.