SENATE BILL NO. 421

INTRODUCED BY G. LIND

A BILL FOR AN ACT ENTITLED: "AN ACT EXPANDING THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM TO COVER PRENATAL CARE FOR PREGNANT WOMEN; AMENDING SECTIONS 53-4-1002, 53-4-1003, 53-4-1004, 53-4-1005, AND 53-4-1007, MCA; AND PROVIDING AN EFFECTIVE DATE AND A TERMINATION DATE."

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

Section 1. Section 53-4-1002, MCA, is amended to read:

"53-4-1002. (Temporary) Purpose -- definition. (1) The purpose of this part is to create a program to provide health care to children and prenatal care to pregnant women who are not eligible for health care services under the Montana medicaid program. These health care services may be provided by the payment for health care through an insurance plan, a health maintenance organization, a managed care plan, or direct payment to a health care provider.

(2) As used in 53-4-1003 through 53-4-1005 and 53-4-1007 through 53-4-1010, "program" means the state children's health insurance program. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999.)"

Section 2. Section 53-4-1003, MCA, is amended to read:

"53-4-1003. (Temporary) Establishment and administration of program. The department of public health and human services may establish, administer, and monitor a program to provide health care to uninsured children and pregnant women. The department may not use money appropriated for this program to expand eligibility criteria for the Montana medicaid program. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999.)"

Section 3. Section 53-4-1004, MCA, is amended to read:

"53-4-1004. (Temporary) Eligibility for program -- rulemaking. (1) ~~To be considered eligible for the program, a child~~ Eligible participants:

(a) must be either a child 18 years of age or younger or a pregnant woman over 18 years of age;

(b) must have a combined family income at or below 150% of the federal poverty level or at a lower level

determined by the department of public health and human services as provided in subsection (4);

(c) may not already be covered by private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c);

(d) may not be eligible for medicaid benefits; and

(e) must be a United States citizen or qualified alien and a Montana resident.

(2) The department of public health and human services shall adopt rules that establish the program's criteria for residency. The criteria must conform as nearly as practicable with the residency requirements for medicaid eligibility.

(3) Subject to 53-4-1009(3), rules governing eligibility may also include financial standards and criteria for income and resources, treatment of resources, and nonfinancial criteria.

(4) If the department determines that there is insufficient funding for the program, it may lower the percentage of the federal poverty level established in subsection (1)(b) in order to reduce the number of persons who may be eligible to participate or may limit the amount, scope, or duration of specific services provided. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999.)"

Section 4. Section 53-4-1005, MCA, is amended to read:

"53-4-1005. (Temporary) Benefits provided. (1) Benefits provided to participants in the program may include but are not limited to:

(a) inpatient and outpatient hospital services;

(b) physician and advanced practice registered nurse services;

(c) laboratory and x-ray services;

(d) well-child and well-baby services;

(e) immunizations;

(f) clinic services;

(g) dental services;

(h) prescription drugs;

(i) mental health and substance abuse treatment services;

(j) hearing and vision exams; ~~and~~

(k) eyeglasses; and

(l) prenatal care for pregnant women.

(2) The department is specifically prohibited from providing payment for birth control contraceptives

under this program. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999.)"

Section 5. Section 53-4-1007, MCA, is amended to read:

"53-4-1007. (Temporary) Department may contract for services. (1) The department of public health and human services may administer the program directly or contract with insurance companies or other entities to provide services for a set monthly or yearly fee based on the number of participants in the program and the types of services provided or based on a fee for service as established by the department.

(2) The department of public health and human services may contract for a health care service based on a fee for service when the department does not contract for a health care service through an insurance plan, a health maintenance organization, or a managed care plan. In operating the program and providing health services, the department may:

(a) pay providers on a fee-for-service basis in a self-funded program and contract with an insurance company, third-party administrator, or other entity to provide administrative services, including but not limited to processing and payment of claims with program funds;

(b) purchase health coverage for eligible children and pregnant women from an insurance company or other entity through premiums, capitated payments, or other appropriate methods;

(c) purchase health coverage as provided in subsection (2)(b) for some types of health services and contract directly with providers for other types of health services on a fee-for-service basis; or

(d) pay providers on a fee-for-service basis and directly provide administrative services in a self-funded program.

(3) If the department of public health and human services contracts with an insurance company or other entity to administer the program as provided in subsection (2)(b) or (2)(c), not more than 12% of the contract payment may be used for administrative expenses, including:

(a) direct and indirect expenses as specified in 33-22-1514;

(b) risk charges; and

(c) any applicable assessments, fees, and taxes.

(4) If the department operates the program by providing administrative services under subsection (2)(a), (2)(c), or (2)(d), the department's administrative expense may not exceed the lesser of 10% or the applicable federal limitation.

(5) (a) An insurance company or other entity that contracts with the department for a fully insured contract as provided in subsection (2)(b) shall calculate the surplus account balance at the end of each contract

year and may retain an amount equal to 50% of the risk charge allowed under the contract. The remainder of the surplus balance must be deposited in the state special revenue account provided for in 53-4-1012.

(b) For the purposes of this subsection (5):

(i) "risk charge" means the percentage of the administrative expense allowed in the contract for assuming the risk;

(ii) "surplus account balance" means funds that remain after all claims and all administrative expenses have been paid for a claim period. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999; sec. 7, Ch. 565, L. 2005.)"

NEW SECTION. **Section 6. Effective date.** [This act] is effective July 1, 2007.

NEW SECTION. **Section 7. Termination.** [This act] terminates on the date that the director of the department of public health and human services certifies to the governor that the federal government has terminated the program or that federal funding for the program has been discontinued.

(2) The governor shall transmit a copy of the certification to the code commissioner.

(3) Any excess funds remaining upon the termination of the program must be transferred to the general fund.

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