

HOUSE BILL NO. 318

INTRODUCED BY E. HILL

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A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING COVERAGE OF CERTAIN THERAPIES FOR CHILDREN WITH DOWN SYNDROME; AMENDING SECTIONS 2-18-704, 33-31-111, AND 33-35-306, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Coverage of therapies for Down syndrome.** (1) Health insurance coverage sold in the group or individual market in this state must provide coverage for diagnosis and treatment of Down syndrome for a covered child 18 years of age or younger.

(2) Coverage under this section must include:

(a) habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child; and

(b) therapeutic care that is provided as follows:

- (i) up to 104 sessions per year with a speech-language pathologist licensed pursuant to Title 37;
- (ii) up to 52 sessions per year with a physical therapist licensed pursuant to Title 37; and
- (iii) up to 52 sessions per year with an occupational therapist licensed pursuant to Title 37.

(3) Habilitative and rehabilitative care includes medically necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention.

(4) Benefits provided under this section may not be construed as limiting physical health benefits that are otherwise available to the covered child.

(5) (a) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions.

(b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical care covered under the plan may not be imposed on the coverage for Down syndrome therapies provided for under this section.



1 (6) When treatment is expected to require continued services, the insurer may request that the treating
2 physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the
3 anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is
4 medically necessary. The treatment plan must be based on evidence-based screening criteria. The insurer may
5 ask that the treatment plan be updated every 6 months.

6 (7) As used in this section, "medically necessary" means any care, treatment, intervention, service, or
7 item that is prescribed, provided, or ordered by a physician licensed in this state and that will or is reasonably
8 expected to:

9 (a) reduce or improve the physical, mental, or developmental effects of Down syndrome; or

10 (b) assist in achieving maximum functional capacity in performing daily activities, taking into account both
11 the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same
12 age.

13 (8) This section applies to the state employee group insurance program, the university system employee
14 group insurance program, any employee group insurance program of a city, town, school district, or other political
15 subdivision of this state, and any self-funded multiple employer welfare arrangement that is not regulated by the
16 Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.

17 (9) This section does not apply to disability income, hospital indemnity, medicare supplement,
18 accident-only, vision, dental, specific disease, or long-term care policies.

19

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

21 **"2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must contain
22 provisions that permit:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (4) (a) A state insurance contract or plan must contain provisions that permit continued membership in

1 the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to
2 be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify
3 the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's
4 choice to continue membership in the group plan.

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

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

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

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

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

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

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

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

22 (b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title
23 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

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

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

26 (b) therapies for Down syndrome, as provided in [section 1].

27 (8) (a) An insurance contract or plan issued under this part that provides coverage for an individual in
28 a member's family must provide coverage for well-child care for children from the moment of birth through 7 years
29 of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in
30 the contract or plan.

1 (b) Coverage for well-child care under subsection (8)(a) must include:

2 (i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory
3 tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment
4 services program provided for in 53-6-101; and

5 (ii) routine immunizations according to the schedule for immunization recommended by the immunization
6 practice advisory committee of the U.S. department of health and human services.

7 (c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided
8 at each visit as provided for in this subsection (8).

9 (d) For purposes of this subsection (8):

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

12 (ii) "well-child care" means the services described in subsection (8)(b) and delivered by a physician or
13 a health care professional supervised by a physician.

14 (9) Upon renewal, an insurance contract or plan issued under this part under which coverage of a
15 dependent terminates at a specified age must continue to provide coverage for any dependent, as defined in the
16 insurance contract or plan, until the dependent reaches 26 years of age. For insurance contracts or plans issued
17 under this part, the premium charged for the additional coverage of a dependent, as defined in the insurance
18 contract or plan, may be required to be paid by the insured and not by the employer.

19 (10) Prior to issuance of an insurance contract or plan under this part, written informational materials
20 describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan
21 member.

22 (11) The state employee group benefit plans and the Montana university system group benefits plans
23 must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician
24 and, in the case of a health maintenance organization, the primary care physician, in consultation with the patient
25 to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment
26 of breast cancer.

27 (12) (a) The state employee group benefit plans and the Montana university system group benefits plans
28 must provide coverage for outpatient self-management training and education for the treatment of diabetes. Any
29 education must be provided by a licensed health care professional with expertise in diabetes.

30 (b) Coverage must include a \$250 benefit for a person each year for medically necessary and prescribed

1 outpatient self-management training and education for the treatment of diabetes.

2 (c) The state employee group benefit plans and the Montana university system group benefits plans must
3 provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes, injection aids,
4 devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading
5 and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive
6 oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug
7 administration, and glucagon emergency kits.

8 (d) Nothing in subsection (12)(a), (12)(b), or (12)(c) prohibits the state or the Montana university group
9 benefit plans from providing a greater benefit or an alternative benefit of substantially equal value, in which case
10 subsection (12)(a), (12)(b), or (12)(c), as appropriate, does not apply.

11 (e) Annual copayment and deductible provisions are subject to the same terms and conditions applicable
12 to all other covered benefits within a given policy.

13 (f) This subsection (12) does not apply to disability income, hospital indemnity, medicare supplement,
14 accident-only, vision, dental, specific disease, or long-term care policies offered by the state or the Montana
15 university system as benefits to employees, retirees, and their dependents.

16 (13) (a) The state employee group benefit plans and the Montana university system group benefits plans
17 that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as
18 defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall
19 renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer
20 firefighter dies within the course and scope of employment. Except as provided in subsection (13)(b), the
21 continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this
22 section must provide for the same level of benefits as are available to other members of the group. Premiums
23 charged to a spouse or dependent under this section must be the same as premiums charged to other similarly
24 situated members of the group. Dependent special enrollment must be allowed under the terms of the insurance
25 contract or plan. The provisions of this subsection (13)(a) are applicable to a spouse or dependent who is insured
26 under a COBRA continuation provision.

27 (b) The state employee group benefit plans and the Montana university system group benefits plans
28 subject to the provisions of subsection (13)(a) may discontinue or not renew the coverage of a spouse or
29 dependent only if:

30 (i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms

1 of the state employee group benefit plans and the Montana university system group benefits plans or if the plans
2 have not received timely premium payments;

3 (ii) the spouse or dependent has performed an act or practice that constitutes fraud or has made an
4 intentional misrepresentation of a material fact under the terms of the coverage; or

5 (iii) the state employee group benefit plans and the Montana university system group benefits plans are
6 ceasing to offer coverage in accordance with applicable state law.

7 (14) The state employee group benefit plans and the Montana university system group benefits plans
8 must comply with the provisions of 33-22-153. (See compiler's comments for contingent termination of certain
9 text.)"

10

11 **Section 3.** Section 33-31-111, MCA, is amended to read:

12 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided
13 in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization
14 authorized to transact business under this chapter. This provision does not apply to an insurer or health service
15 corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state
16 except with respect to its health maintenance organization activities authorized and regulated pursuant to this
17 chapter.

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

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

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

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

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

29 (a) prohibitions against interference with certain communications as provided under Title 33, chapter 1,
30 part 8;

1 (b) the provisions of Title 33, chapter 22, part 19;
 2 (c) the requirements of 33-22-134 and 33-22-135;
 3 (d) network adequacy and quality assurance requirements provided under chapter 36; or
 4 (e) the requirements of Title 33, chapter 18, part 9.
 5 (7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212,
 6 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,
 7 33-22-131, 33-22-136, 33-22-137, 33-22-138, [section 1], 33-22-141, 33-22-142, 33-22-152, 33-22-153,
 8 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,
 9 33-22-524, 33-22-526, 33-22-706], and Title 33, chapter 40, part 1,] apply to health maintenance organizations.
 10 (Bracketed language in (7) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

11
 12 **Section 4.** Section 33-35-306, MCA, is amended to read:
 13 **"33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter,
 14 self-funded multiple employer welfare arrangements are subject to the following provisions:
 15 (a) 33-1-111;
 16 (b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare
 17 arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;
 18 (c) Title 33, chapter 1, part 7;
 19 (d) 33-3-308;
 20 (e) Title 33, chapter 18, except 33-18-242;
 21 (f) Title 33, chapter 19;
 22 (g) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-138, [section 1], 33-22-141, 33-22-142,
 23 33-22-152, and 33-22-153;
 24 (h) 33-22-512, 33-22-515, 33-22-525, and 33-22-526; and
 25 (i) Title 33, chapter 40, part 1.
 26 (2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple
 27 employer welfare arrangement that has been issued a certificate of authority that has not been revoked.
 28 (Subsection (1)(i) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

29
 30 **NEW SECTION. Section 5. Codification instruction.** [Section 1] is intended to be codified as an

1 integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 1].

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3 NEW SECTION. **Section 6. Effective date.** [This act] is effective January 1, 2016.

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