

1 SENATE BILL NO. 149

2 INTRODUCED BY M. ROSENDALE

3

4 A BILL FOR AN ACT ENTITLED: "AN ACT AUTHORIZING DIRECT PRIMARY CARE PROVIDER PLANS;
5 ESTABLISHING REQUIREMENTS FOR DIRECT PRIMARY CARE PROVIDER PLANS; ESTABLISHING THAT
6 DIRECT PRIMARY CARE PROVIDER PLANS ARE NOT HEALTH INSURANCE; MAKING DIRECT PRIMARY
7 CARE PROVIDER PLANS SUBJECT TO CONSUMER PROTECTION LAWS; AND AMENDING SECTIONS
8 30-14-102, 33-1-102, 33-1-201, 33-1-207, 33-22-140, 33-30-101, AND 33-31-102, MCA."

9

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

11

12 NEW SECTION. **Section 1. Definitions.** As used in [sections 1 through 4], the following definitions
13 apply:

14 (1) "Direct primary care provider plan" means a plan offered by a primary care provider, group, entity,
15 or practice in which fees are collected on a prepaid basis in order to provide primary health care for enrollees.

16 (2) "Enrollee" means an individual, family, or group that has enrolled in a direct primary care provider
17 plan.

18 (3) "Health insurance issuer" has the meaning provided in 33-22-140.

19 (4) "Primary care provider" means:

20 (a) any of the following individuals who are licensed pursuant to Title 37 and who specialize in or are
21 board-certified in general practice, family medicine, internal medicine, or pediatrics:

22 (i) a physician;

23 (ii) a physician assistant whose duties and delegation agreement allows for participation in a direct
24 primary care provider plan; or

25 (iii) an advanced practice registered nurse authorized by the board of nursing to prescribe medicine; or

26 (b) a chiropractor licensed pursuant to Title 37, chapter 12.

27 (5) "Primary health care" means all components of primary care that are ordered and supervised by a
28 primary care provider, including medical visits, laboratory testing, imaging, pathology testing, prescribing and
29 administering medication, and other medical procedures that may be performed or supervised by a primary care
30 provider with training and experience in the procedure.

1 (6) "Provider access" means the method and manner in which an enrollee may obtain primary health
2 care from a primary care provider and the frequency with which an enrollee may obtain the services under the
3 direct primary care provider plan.

4
5 **NEW SECTION. Section 2. Direct primary care provider plans -- requirements -- notice.** (1) A direct
6 primary care provider plan may arrange for primary health care for enrollees.

7 (2) A direct primary care provider plan must be in writing, and each enrollee must be given a copy of the
8 written plan at the time the enrollee signs the plan.

9 (3) The plan must describe:

10 (a) the provider access and the primary health care services that the plan will provide;

11 (b) the enrollee's total payment obligation; and

12 (c) the terms of cancellation, including terms that cover relocation or military duty by an enrollee.

13 (4) An enrollee may cancel a direct primary care provider plan for any reason on written notice to the plan
14 provider.

15
16 **NEW SECTION. Section 3. Direct primary care provider plans -- prohibitions.** A direct primary care
17 provider plan may not:

18 (1) charge different fees for comparable services based on an enrollee's health status or gender; or

19 (2) submit to a health insurance issuer or a contractor or subcontractor of a health insurance issuer a
20 claim for payment for primary health care services provided to an enrollee.

21
22 **NEW SECTION. Section 4. Disclosure required.** A direct primary care provider plan must provide a
23 written disclaimer that is either printed on or accompanies all application and guideline materials distributed by
24 or on behalf of the plan. The disclaimer must read substantially as follows:

25 Notice: The organization facilitating the direct primary care provider plan is not an insurance company,
26 and the direct primary care company guidelines and plan operation are not an insurance policy. Participation in
27 the direct primary care provider plan or a subscription to any of its documents should not be considered to be a
28 health insurance policy. Regardless of whether you receive treatment for medical issues through the direct
29 primary care provider plan, you are always personally responsible for the payment of any additional medical
30 expenses that you may incur.

1

2 **Section 5.** Section 30-14-102, MCA, is amended to read:

3 **"30-14-102. Definitions.** As used in this part, the following definitions apply:

4 (1) "Consumer" means a person who purchases or leases goods, services, real property, or information
5 primarily for personal, family, or household purposes.

6 (2) "Department" means the department of justice created in 2-15-2001.

7 (3) "Documentary material" means the original or a copy of any book, record, report, memorandum,
8 paper, communication, tabulation, map, chart, photograph, mechanical transcription, or other tangible document
9 or recording.

10 (4) "Examination" of documentary material includes the inspection, study, or copying of documentary
11 material and the taking of testimony under oath or acknowledgment in respect to any documentary material or
12 copy of documentary material.

13 (5) (a) "Gift certificate" means a record, including a gift card or stored value card, that is provided for paid
14 consideration and that indicates a promise by the issuer or seller of the record that goods or services will be
15 provided to the possessor of the record for the value that is shown on the record or contained within the record
16 by means of a microprocessor chip, magnetic stripe, bar code, or other electronic information storage device. The
17 consideration provided for the gift certificate must be made in advance. The value of the gift certificate is reduced
18 by the amount spent with each use. A gift certificate is considered trust property of the possessor if the issuer or
19 seller of the gift certificate declares bankruptcy after issuing or selling the gift certificate. The value represented
20 by the gift certificate belongs to the possessor, to the extent provided by law, and not to the issuer or seller.

21 (b) The term does not include:

22 (i) prepaid telecommunications and technology cards, including but not limited to prepaid telephone
23 calling cards, prepaid technical support cards, and prepaid internet disks that have been distributed to or
24 purchased by a consumer;

25 (ii) a coupon provided to a consumer pursuant to any award, loyalty, or promotion program without any
26 money or consideration being given in exchange for the card; or

27 (iii) a gift certificate usable with multiple sellers of goods or services.

28 (6) "Person" means natural persons, corporations, trusts, partnerships, incorporated or unincorporated
29 associations, and any other legal entity.

30 (7) "Possessor" means a natural person who has physical control over a gift certificate.

1 (8) (a) "Trade" and "commerce" mean the advertising, offering for sale, sale, or distribution of any
 2 services, any property, tangible or intangible, real, personal, or mixed, or any other article, commodity, or thing
 3 of value, wherever located, and includes any trade or commerce directly or indirectly affecting the people of this
 4 state.

5 (b) The term includes direct primary care provider plans as defined in [section 1]."
 6

7 **Section 6.** Section 33-1-102, MCA, is amended to read:

8 **"33-1-102. (Temporary) Compliance required -- exceptions -- health service corporations -- health**
 9 **maintenance organizations -- governmental insurance programs -- service contracts.** (1) A person may not
 10 transact a business of insurance in Montana or a business relative to a subject resident, located, or to be
 11 performed in Montana without complying with the applicable provisions of this code.

12 (2) The provisions of this code do not apply with respect to:

13 (a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

14 (b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

15 (c) fraternal benefit societies, except as stated in chapter 7.

16 (3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the
 17 corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

18 (4) Except as provided in Title 33, chapter 40, part 1, this code does not apply to health maintenance
 19 organizations to the extent that the existence and operations of those organizations are governed by chapter 31.

20 (5) This code does not apply to workers' compensation insurance programs provided for in Title 39,
 21 chapter 71, parts 21 and 23, and related sections.

22 (6) The department of public health and human services may limit the amount, scope, and duration of
 23 services for programs established under Title 53 that are provided under contract by entities subject to this title.
 24 The department of public health and human services may establish more restrictive eligibility requirements and
 25 fewer services than may be required by this title.

26 (7) This code does not apply to the state employee group insurance program established in Title 2,
 27 chapter 18, part 8, or the Montana university system group benefits plans established in Title 20, chapter 25, part
 28 13.

29 (8) This code does not apply to insurance funded through the state self-insurance reserve fund provided
 30 for in 2-9-202.

1 (9) (a) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement,
2 plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions
3 undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or
4 self-insurance plan.

5 (b) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement,
6 plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program
7 of a single political subdivision of this state in which the political subdivision provides to its officers, elected
8 officials, or employees disability insurance or life insurance through a self-funded program.

9 (10) (a) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making
10 of, proposal to make, and administration of a service contract.

11 (b) A "service contract" means a contract or agreement for a separately stated consideration for a
12 specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair,
13 replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or
14 manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or
15 indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service.
16 A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from
17 power surges or accidental damage from handling. A service contract does not include motor club service as
18 defined in 61-12-301.

19 (11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance
20 services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for
21 the financial risk under the contract with the third party as provided in 7-34-103.

22 (b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or
23 town, the entity is subject to the provisions of this code.

24 (12) Except as provided in Title 33, chapter 40, part 1, this code does not apply to the self-insured student
25 health plan established in Title 20, chapter 25, part 14.

26 (13) This code does not apply to private air ambulance services that are in compliance with 50-6-320 and
27 that solicit membership subscriptions, accept membership applications, charge membership fees, and provide
28 air ambulance services to subscription members and designated members of their households.

29 (14) This code does not apply to guaranteed asset protection waivers that are governed by 30-14-151
30 through 30-14-157.

1 (15) This code does not apply to direct primary care provider plans established pursuant to [sections 1
2 through 4] if the plan does not assume financial risk or agree to indemnify for services by a third party.
3 (Terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)

4 **33-1-102. (Effective January 1, 2018) Compliance required -- exceptions -- health service**
5 **corporations -- health maintenance organizations -- governmental insurance programs -- service**
6 **contracts.** (1) A person may not transact a business of insurance in Montana or a business relative to a subject
7 resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

8 (2) The provisions of this code do not apply with respect to:

9 (a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

10 (b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

11 (c) fraternal benefit societies, except as stated in chapter 7.

12 (3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the
13 corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

14 (4) This code does not apply to health maintenance organizations to the extent that the existence and
15 operations of those organizations are governed by chapter 31.

16 (5) This code does not apply to workers' compensation insurance programs provided for in Title 39,
17 chapter 71, parts 21 and 23, and related sections.

18 (6) The department of public health and human services may limit the amount, scope, and duration of
19 services for programs established under Title 53 that are provided under contract by entities subject to this title.
20 The department of public health and human services may establish more restrictive eligibility requirements and
21 fewer services than may be required by this title.

22 (7) This code does not apply to the state employee group insurance program established in Title 2,
23 chapter 18, part 8, or the Montana university system group benefits plans established in Title 20, chapter 25, part
24 13.

25 (8) This code does not apply to insurance funded through the state self-insurance reserve fund provided
26 for in 2-9-202.

27 (9) (a) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement,
28 plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions
29 undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or
30 self-insurance plan.

1 (b) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement,
2 plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program
3 of a single political subdivision of this state in which the political subdivision provides to its officers, elected
4 officials, or employees disability insurance or life insurance through a self-funded program.

5 (10) (a) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making
6 of, proposal to make, and administration of a service contract.

7 (b) A "service contract" means a contract or agreement for a separately stated consideration for a
8 specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair,
9 replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or
10 manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or
11 indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service.
12 A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from
13 power surges or accidental damage from handling. A service contract does not include motor club service as
14 defined in 61-12-301.

15 (11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance
16 services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for
17 the financial risk under the contract with the third party as provided in 7-34-103.

18 (b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or
19 town, the entity is subject to the provisions of this code.

20 (12) This code does not apply to the self-insured student health plan established in Title 20, chapter 25,
21 part 14.

22 (13) This code does not apply to private air ambulance services that are in compliance with 50-6-320 and
23 that solicit membership subscriptions, accept membership applications, charge membership fees, and provide
24 air ambulance services to subscription members and designated members of their households.

25 (14) This code does not apply to guaranteed asset protection waivers that are governed by 30-14-151
26 through 30-14-157.

27 (15) This code does not apply to direct primary care provider plans established pursuant to [sections 1
28 through 4] if the plan does not assume financial risk or agree to indemnify for services by a third party."

29

30 **Section 7.** Section 33-1-201, MCA, is amended to read:

1 **"33-1-201. Definitions -- insurance in general.** For the purposes of this code, the following definitions
2 apply unless the context requires otherwise:

3 (1) "Alien insurer" is an insurer formed under the laws of any country other than the United States or its
4 states, districts, territories, and commonwealths.

5 (2) "Authorized insurer" is an insurer duly authorized by a certificate of authority issued by the
6 commissioner to transact insurance in this state.

7 (3) "Domestic insurer" is an insurer incorporated under the laws of this state.

8 (4) "Foreign insurer" is an insurer formed under the laws of any jurisdiction other than this state. Except
9 when distinguished by context, the term includes an alien insurer.

10 (5) (a) "Insurance" is a contract through which one undertakes to indemnify another or pay or provide
11 a specified or determinable amount or benefit upon determinable contingencies.

12 (b) Insurance does not include:

13 (i) contracts for the installation, maintenance, and provision of inside telecommunications wiring to
14 residential or business premises; or

15 (ii) direct primary care provider plans as defined in [section 1].

16 (6) "Insurer" includes every person engaged as indemnitor, surety, or contractor in the business of
17 entering into contracts of insurance. The term also includes a health service corporation in the provisions listed
18 in 33-30-102.

19 (7) "Resident domestic insurer" is an insurer incorporated under the laws of this state and:

20 (a) if a mutual company, not less than one-half of the policyholders are individuals who are residents of
21 this state; or

22 (b) if a stock insurer, not less than one-half of the shares are owned by individuals who are residents
23 of this state and all of the directors and officers of the insurer are residents of this state.

24 (8) "State", when used in relation to jurisdiction, means a state, the District of Columbia, or a territory,
25 commonwealth, or possession of the United States.

26 (9) "Transact", with respect to insurance, means to:

27 (a) solicit;

28 (b) negotiate;

29 (c) sell or effectuate a contract of insurance; or

30 (d) transact matters subsequent to effectuation of the contract of insurance and arising out of it.

1 (10) "Unauthorized insurer" is an insurer not authorized by a certificate of authority issued by the
2 commissioner to transact insurance in this state."

3

4 **Section 8.** Section 33-1-207, MCA, is amended to read:

5 **"33-1-207. Disability insurance.** (1) Disability insurance, including credit disability insurance, is
6 insurance of human beings:

7 (a) against bodily injury, disablement, or death by accident or accidental means or the medical expense
8 or indemnity involved; or

9 (b) against disablement or medical expense or indemnity resulting from sickness.

10 (2) Transaction of disability insurance does not include:

11 (a) workers' compensation insurance; or

12 (b) a direct primary care provider plan as defined in [section 1] if the plan does not assume financial risk
13 or agree to indemnify for services provided by a third party."

14

15 **Section 9.** Section 33-22-140, MCA, is amended to read:

16 **"33-22-140. Definitions.** As used in this chapter, unless the context requires otherwise, the following
17 definitions apply:

18 (1) "Beneficiary" has the meaning given the term by 29 U.S.C. 1002(33).

19 (2) "Church plan" has the meaning given the term by 29 U.S.C. 1002(33).

20 (3) "COBRA continuation provision" means:

21 (a) section 4980B of the Internal Revenue Code, 26 U.S.C. 4980B, other than subsection (f)(1) of that
22 section as that subsection relates to pediatric vaccines;

23 (b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of
24 1974, 29 U.S.C. 1001, et seq.; or

25 (c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.

26 (4) (a) "Creditable coverage" means coverage of the individual under any of the following:

27 (i) a group health plan;

28 (ii) health insurance coverage;

29 (iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j
30 through 1395w-4;

- 1 (iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting
2 solely of a benefit under section 1928, 42 U.S.C. 1396s;
- 3 (v) Title 10, chapter 55, United States Code;
- 4 (vi) a medical care program of the Indian health service or of a tribal organization;
- 5 (vii) the Montana comprehensive health association provided for in 33-22-1503;
- 6 (viii) a health plan offered under Title 5, chapter 89, of the United States Code;
- 7 (ix) a public health plan;
- 8 (x) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);
- 9 (xi) a high-risk pool in any state.
- 10 (b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.
- 11 (5) "Dependent" means:
- 12 (a) a spouse;
- 13 (b) an unmarried child under 25 years of age:
- 14 (i) who is not an employee eligible for coverage under a group health plan offered by the child's employer
15 for which the child's premium contribution amount is no greater than the premium amount for coverage as a
16 dependent under a parent's individual or group health plan;
- 17 (ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual
18 health insurance coverage, group health plan, government plan, church plan, or group health insurance;
- 19 (iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and
- 20 (iv) for whom the insured parent has requested coverage;
- 21 (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and
22 33-30-1003; or
- 23 (d) any other individual defined as a dependent in the health benefit plan covering the employee.
- 24 (6) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific
25 condition that would otherwise be covered under the policy.
- 26 (7) "Enrollment date" means, with respect to an individual covered under a group health plan or health
27 insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of
28 the waiting period for enrollment.
- 29 (8) "Excepted benefits" means:
- 30 (a) coverage only for accident or disability income insurance, or both;

- 1 (b) coverage issued as a supplement to liability insurance;
- 2 (c) liability insurance, including general liability insurance and automobile liability insurance;
- 3 (d) workers' compensation or similar insurance;
- 4 (e) automobile medical payment insurance;
- 5 (f) credit-only insurance;
- 6 (g) coverage for onsite medical clinics;
- 7 (h) other similar insurance coverage under which benefits for medical care are secondary or incidental
- 8 to other insurance benefits, as approved by the commissioner;
- 9 (i) if offered separately, any of the following:
- 10 (i) limited-scope dental or vision benefits;
- 11 (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any
- 12 combination of these types of care; or
- 13 (iii) other similar, limited benefits as approved by the commissioner;
- 14 (j) if offered as independent, noncoordinated benefits, any of the following:
- 15 (i) coverage only for a specified disease or illness; or
- 16 (ii) hospital indemnity or other fixed indemnity insurance;
- 17 (k) if offered as a separate insurance policy:
- 18 (i) medicare supplement coverage;
- 19 (ii) coverage supplemental to the coverage provided under Title 10, chapter 55, of the United States
- 20 Code; and
- 21 (iii) similar supplemental coverage provided under a group health plan.
- 22 (9) "Federally defined eligible individual" means an individual:
- 23 (a) for whom, as of the date on which the individual seeks coverage in the group market or individual
- 24 market or under an association portability plan, as defined in 33-22-1501, the aggregate of the periods of
- 25 creditable coverage is 18 months or more;
- 26 (b) whose most recent prior creditable coverage was under a group health plan, governmental plan,
- 27 church plan, or health insurance coverage offered in connection with any of those plans;
- 28 (c) who is not eligible for coverage under:
- 29 (i) a group health plan;
- 30 (ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j

1 through 1395w-4; or

2 (iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor
3 program;

4 (d) who does not have other health insurance coverage;

5 (e) for whom the most recent coverage within the period of aggregate creditable coverage was not
6 terminated for factors relating to nonpayment of premiums or fraud;

7 (f) who, if offered the option of continuation coverage under a COBRA continuation provision or under
8 a similar state program, elected that coverage; and

9 (g) who has exhausted continuation coverage under the COBRA continuation provision or program
10 described in subsection (9)(f) if the individual elected the continuation coverage described in subsection (9)(f).

11 (10) "Group health insurance coverage" means health insurance coverage offered in connection with a
12 group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.

13 (11) "Group health plan" means an employee welfare benefit plan, as defined in 29 U.S.C. 1002(1), to
14 the extent that the plan provides medical care and items and services paid for as medical care to employees or
15 their dependents, directly or through insurance, reimbursement, or otherwise.

16 (12) "Health insurance coverage" means benefits consisting of medical care, including items and services
17 paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a
18 policy, certificate, membership contract, or health care services agreement offered by a health insurance issuer.

19 (13) (a) "Health insurance issuer" means an insurer, a health service corporation, or a health
20 maintenance organization.

21 (b) The term does not include a direct primary care provider plan as defined in [section 1].

22 (14) "Individual health insurance coverage" means health insurance coverage offered to individuals in
23 the individual market, but does not include short-term limited duration insurance.

24 (15) "Individual market" means the market for health insurance coverage offered to individuals other than
25 in connection with group health insurance coverage.

26 (16) "Large employer" means, in connection with a group health plan, with respect to a calendar year and
27 a plan year, an employer who employed an average of at least 51 employees on business days during the
28 preceding calendar year and who employs at least two employees on the first day of the plan year.

29 (17) "Large group market" means the health insurance market under which individuals obtain health
30 insurance coverage directly or through any arrangement on behalf of themselves and their dependents through

1 a group health plan or group health insurance coverage issued to a large employer.

2 (18) "Late enrollee" means an eligible employee or dependent, other than a special enrollee under
3 33-22-523, who requests enrollment in a group health plan following the initial enrollment period during which the
4 individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a
5 period of at least 30 days. However, an eligible employee or dependent is not considered a late enrollee if a court
6 has ordered that coverage be provided for a spouse, minor, or dependent under a covered employee's health
7 benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

8 (19) "Medical care" means:

9 (a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose
10 of affecting any structure or function of the body;

11 (b) transportation primarily for and essential to medical care referred to in subsection (19)(a); or

12 (c) insurance covering medical care referred to in subsections (19)(a) and (19)(b).

13 (20) "Network plan" means health insurance coverage offered by a health insurance issuer under which
14 the financing and delivery of medical care, including items and services paid for as medical care, are provided,
15 in whole or in part, through a defined set of providers under contract with the issuer.

16 (21) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement
17 Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

18 (22) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of
19 benefits relating to a condition based on presence of a condition before the enrollment date coverage, whether
20 or not any medical advice, diagnosis, care, or treatment was recommended or received before the enrollment
21 date.

22 (23) "Small group market" means the health insurance market under which individuals obtain health
23 insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through
24 a group health plan or group health insurance coverage maintained by a small employer as defined in
25 33-22-1803.

26 (24) "Waiting period" means, with respect to a group health plan and an individual who is a potential
27 participant or beneficiary in the group health plan, the period that must pass with respect to the individual before
28 the individual is eligible to be covered for benefits under the terms of the group health plan."
29

30 **Section 10.** Section 33-30-101, MCA, is amended to read:

1 **"33-30-101. Definitions.** As used in this chapter, the following definitions apply:

2 (1) (a) "Health service corporation" means a nonprofit corporation organized or operating for the purposes
3 of establishing and operating a nonprofit plan or plans under which prepaid hospital care, medical-surgical care,
4 and other health care and services, or reimbursement therefor, may be furnished to a member or beneficiary.

5 (b) The term does not include a direct primary care provider plan as defined in [section 1].

6 (2) "Health services" means the health care and services provided by hospitals or other health care
7 institutions, organizations, associations, or groups and by doctors of medicine, osteopathy, dentistry, chiropractic,
8 optometry, and podiatry; nursing services; licensed acupuncturist services; licensed social worker, licensed
9 professional counselor, or psychologist; medical appliances, equipment, and supplies; drugs, medicines,
10 ambulance services, and other therapeutic services and supplies.

11 (3) "Membership contract" means any agreement, contract, or certificate by which a health service
12 corporation describes the health services or benefits provided to its members or beneficiaries."

13

14 **Section 11.** Section 33-31-102, MCA, is amended to read:

15 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the following
16 definitions apply:

17 (1) "Accountable care organization" means a group of health care providers that are willing and capable
18 of accepting accountability for the total cost and quality of care for a defined population.

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

21 (3) "Basic health care services" means:

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

23 (b) inpatient hospital and provider care;

24 (c) outpatient medical services;

25 (d) medical treatment and referral services;

26 (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to
27 33-31-301(3)(e);

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

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

30 (h) preventive health services, including:

- 1 (i) immunizations;
- 2 (ii) well-child care from birth;
- 3 (iii) periodic health evaluations for adults;
- 4 (iv) voluntary family planning services;
- 5 (v) infertility services; and
- 6 (vi) children's eye and ear examinations conducted to determine the need for vision and hearing
- 7 correction;
- 8 (i) minimum mammography examination, as defined in 33-22-132;
- 9 (j) outpatient self-management training and education for the treatment of diabetes along with certain
- 10 diabetic equipment and supplies as provided in 33-22-129; and
- 11 (k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have
- 12 the meanings provided for in 33-22-131.
- 13 (4) "Commissioner" means the commissioner of insurance of the state of Montana.
- 14 (5) "Dependent" has the meaning provided in 33-22-140.
- 15 (6) "Enrollee" means a person:
- 16 (a) who enrolls in or contracts with a health maintenance organization;
- 17 (b) on whose behalf a contract is made with a health maintenance organization to receive health care
- 18 services; or
- 19 (c) on whose behalf the health maintenance organization contracts to receive health care services.
- 20 (7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee
- 21 setting forth the coverage to which the enrollee is entitled.
- 22 (8) "Health care services" means:
- 23 (a) the services included in furnishing medical or dental care to a person;
- 24 (b) the services included in hospitalizing a person;
- 25 (c) the services incident to furnishing medical or dental care or hospitalization; or
- 26 (d) the services included in furnishing to a person other services for the purpose of preventing,
- 27 alleviating, curing, or healing illness, injury, or physical disability.
- 28 (9) "Health care services agreement" means an agreement for health care services between a health
- 29 maintenance organization and an enrollee.
- 30 (10) (a) "Health maintenance organization" means a person who provides or arranges for basic health

1 care services to enrollees on a prepaid basis, either directly through provider employees or through contractual
2 or other arrangements with a provider or a group of providers. This subsection does not limit methods of provider
3 payments made by health maintenance organizations.

4 (b) The term does not apply to:

5 (i) a PACE organization or an accountable care organization that has received a waiver pursuant to
6 33-31-201; or

7 (ii) a direct primary care provider plan as defined in [section 1].

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

10 (12) "PACE organization" means an organization, as defined in 42 CFR 460.6, that is authorized by the
11 centers for medicare and medicaid services and the department of public health and human services to operate
12 a program of all-inclusive care for the elderly.

13 (13) "Person" means:

14 (a) an individual;

15 (b) a group of individuals;

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

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

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

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

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

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

27 (16) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist,
28 osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or
29 advanced practice registered nurse, as specifically listed in 37-8-202, or registered nurse first assistant as defined
30 by the board of nursing under Title 37, chapter 8, who treats any illness or injury within the scope and limitations

1 of the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health
2 care services.

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

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

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

10
11 NEW SECTION. **Section 12. Codification instruction.** [Sections 1 through 4] are intended to be
12 codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [sections 1
13 through 4].

14 - END -