HOUSE BILL NO. 406

INTRODUCED BY K. GILLAN, BOHLINGER, R. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE ~~OF ALL MEDICALLY NECESSARY EXPENSES ASSOCIATED WITH THE TREATMENT OF DIABETES; DEFINING "MEDICALLY NECESSARY";~~ FOR OUTPATIENT SELF-MANAGEMENT TRAINING AND EDUCATION FOR THE TREATMENT OF DIABETES AND A LIMITED BENEFIT FOR CERTAIN DIABETIC EQUIPMENT AND SUPPLIES; REQUIRING THAT MANDATORY COVERAGE ~~FOR MEDICALLY NECESSARY EXPENSES ASSOCIATED WITH THE TREATMENT OF DIABETES~~ APPLY TO COVERAGE BY HEALTH MAINTENANCE ORGANIZATIONS ~~AND TO COVERAGE OFFERED BY MULTIPLE EMPLOYER WELFARE ARRANGEMENTS~~; PROVIDING THAT STATE AND LOCAL GOVERNMENT EMPLOYEE PLANS ARE NOT INCLUDED IF THE PLANS PROVIDE EQUIVALENT OR GREATER COVERAGE; AMENDING SECTIONS 2-18-704, 33-31-102, AND 33-31-111, ~~AND 33-35-306,~~ MCA; AND PROVIDING ~~AN~~ A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Coverage for OUTPATIENT SELF-MANAGEMENT TRAINING AND EDUCATION FOR treatment of diabetes -- LIMITED BENEFIT FOR MEDICALLY NECESSARY EQUIPMENT AND SUPPLIES.** (1) Each group ~~or individual~~ disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for ~~the treatment of diabetes.~~

~~(2) Coverage must include all medically necessary and prescribed expenses related to diagnosis, monitoring, treatment, control,~~ OUTPATIENT SELF-MANAGEMENT TRAINING and education for ~~self-management~~ THE TREATMENT of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes.

~~(3) For the purposes of this section, "medically necessary" means services, including self-management education and medical nutrition therapy, medicines, equipment, and supplies that are necessary and appropriate for the diagnosis or treatment of a covered person's type 1, type 2, or gestational diabetes according to accepted standards of medical practice.~~

~~(4) The coverage in subsection (2) is subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes deductibles and copayment provisions as long as the terms are not less favorable than for physical illness generally.~~

(2) (A) COVERAGE MUST INCLUDE A $250 BENEFIT FOR A PERSON EACH YEAR FOR MEDICALLY NECESSARY AND PRESCRIBED OUTPATIENT SELF-MANAGEMENT TRAINING AND EDUCATION FOR THE TREATMENT OF DIABETES.

(B) NOTHING IN SUBSECTION (2)(A) PROHIBITS AN INSURER FROM PROVIDING A GREATER BENEFIT.

(3) EACH GROUP DISABILITY POLICY, CERTIFICATE OF INSURANCE, AND MEMBERSHIP CONTRACT THAT IS DELIVERED, ISSUED FOR DELIVERY, RENEWED, EXTENDED, OR MODIFIED IN THIS STATE MUST PROVIDE COVERAGE FOR DIABETIC EQUIPMENT AND SUPPLIES THAT IS LIMITED TO INSULIN, SYRINGES, INJECTION AIDS, DEVISES FOR SELF-MONITORING OF GLUCOSE LEVELS (INCLUDING THOSE FOR THE VISUALLY IMPAIRED), TEST STRIPS, VISUAL READING AND URINE TEST STRIPS, ONE INSULIN PUMP FOR EACH WARRANTY PERIOD, ACCESSORIES TO INSULIN PUMPS, ONE PRESCRIPTIVE ORAL AGENT FOR CONTROLLING BLOOD SUGAR LEVELS FOR EACH CLASS OF DRUG APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION, AND GLUCAGON EMERGENCY KITS.

(4) ANNUAL COPAYMENT AND DEDUCTIBLE PROVISIONS ARE SUBJECT TO THE SAME TERMS AND CONDITIONS APPLICABLE TO ALL OTHER COVERED BENEFITS WITHIN A GIVEN POLICY.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, ~~or~~ specific disease, OR LONG-TERM CARE policies.

(6) (A) THIS SECTION DOES NOT APPLY TO THE STATE EMPLOYEE GROUP INSURANCE PROGRAM, THE UNIVERSITY EMPLOYEE GROUP INSURANCE PROGRAM, OR ANY EMPLOYEE GROUP INSURANCE PROGRAM OF A CITY, TOWN, COUNTY, SCHOOL DISTRICT, OR OTHER POLITICAL SUBDIVISION OF THIS STATE THAT ON [THE EFFECTIVE DATE OF THIS ACT] PROVIDES SUBSTANTIALLY EQUIVALENT OR GREATER COVERAGE FOR OUTPATIENT SELF-MANAGEMENT TRAINING AND EDUCATION FOR THE TREATMENT OF DIABETES AND CERTAIN DIABETIC EQUIPMENT AND SUPPLIES PROVIDED FOR IN SUBSECTION (3).

(B) THE STATE EMPLOYEE GROUP INSURANCE PROGRAM, THE UNIVERSITY EMPLOYEE GROUP INSURANCE PROGRAM, OR ANY EMPLOYEE GROUP INSURANCE PROGRAM OF A CITY, TOWN, COUNTY, SCHOOL DISTRICT, OR OTHER POLITICAL SUBDIVISION OF THIS STATE THAT REDUCES OR DISCONTINUES SUBSTANTIALLY EQUIVALENT OR GREATER COVERAGE AFTER [THE EFFECTIVE DATE OF THIS ACT] IS SUBJECT TO THE PROVISIONS OF THIS SECTION.

SECTION 2. SECTION 2-18-704, MCA, IS AMENDED TO READ:

"2-18-704. (Temporary) 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 provided by law 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 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 [section 1].

2-18-704. (Effective on occurrence of contingency or July 1, 2002, whichever is earlier) 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 [section 1]."

Section 3. 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);

(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; ~~and~~

(j) ~~medically necessary~~ OUTPATIENT SELF-MANAGEMENT TRAINING AND EDUCATION FOR THE treatment ~~for~~

OF diabetes ALONG WITH CERTAIN DIABETIC EQUIPMENT AND SUPPLIES as provided in [section 1]; and

~~(j)~~(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 4. Section 33-31-111, MCA, is amended to read:

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

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

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is

exempt from Title 37, chapter 3, relating to the practice of medicine.

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

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

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

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

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Chapter 1, parts 12 and 13, of this title, 33-3-431, 33-15-308, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-246, 33-22-247, 33-22-514, 33-22-523, 33-22-524, 33-22-526, ~~and~~ 33-22-706, and [section 1] apply to health maintenance organizations."

~~**Section 5.** Section 33-35-306, MCA, is amended to read:~~

~~**"33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions of Title 33:~~

~~(a) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;~~

~~(b) Title 33, chapter 1, part 7;~~

~~(c) 33-3-308;~~

~~(d) Title 33, chapter 18, except 33-18-242;~~

~~(e) 33-22-131, 33-22-134, and 33-22-135,; and~~

~~(f) 33-22-525, and 33-22-526, and [section 1].~~

~~(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."~~

NEW SECTION. **SECTION 5. APPLICATION TO TYPES OF INSURANCE.** THE PROVISIONS OF [SECTION 1(1) AND

(2)] APPLY IF THE STATE EMPLOYEE GROUP INSURANCE PROGRAM, THE UNIVERSITY EMPLOYEE GROUP INSURANCE PROGRAM, OR ANY EMPLOYEE GROUP INSURANCE PROGRAM OF A CITY, TOWN, COUNTY, SCHOOL DISTRICT, OR OTHER POLITICAL SUBDIVISION OF THIS STATE REDUCES OR DISCONTINUES SUBSTANTIALLY EQUIVALENT OR GREATER COVERAGE FOR OUTPATIENT SELF-MANAGEMENT TRAINING AND EDUCATION FOR THE TREATMENT OF DIABETES AND CERTAIN DIABETIC EQUIPMENT AND SUPPLIES.

NEW SECTION. **Section 6. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [section 1].

NEW SECTION. **Section 7. Effective date -- applicability.** [This act] is effective ~~July 1, 2001~~ JANUARY 1, 2002, and applies to all policies, contracts, plans, or certificates issued or renewed on or after that date.

- END -