**** Bill No. ****

Introduced By **********

By Request of the *********

A Bill for an Act entitled: "An Act providing insurance parity for mental illness and chemical dependency; amending sections 33-22-262, 33-22-701, 33-22-702, 33-22-706, and 33-22-1521, MCA; repealing sections 33-22-703, 33-22-704, and 33-22-705, MCA; and providing an applicability date."

Be it enacted by the Legislature of the State of Montana:

Section 1. Section 33-22-262, MCA, is amended to read:

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

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

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

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

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

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

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

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

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

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

(c) coverage for mental health services, as provided in

33-31-301(3)(g)(i);

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

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

(f) services provided by a specific category of licensed health care practitioner to be provided to the covered person for a health-related condition in a health benefit plan or managed care plan, including services described in 33-22-125 and 33-30-1017;

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

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

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

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

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

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

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

(5) Upon a renewal request and approval by the insurance

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

{*Internal References to 33-22-262:*
33-22-263 x *33-22-301 x* *33-22-301 x* *33-22-706x*
33-22-706 x *33-30-1001 x* *33-31-111 x* *33-31-111x*
33-31-202 x *33-31-301 x* *33-31-301x* *33-31-301x*
33-31-301 x *33-36-201 x* *33-36-205*x*}

Section 2. Section 33-22-701, MCA, is amended to read:

"33-22-701. Scope of part -- purpose ~~-- exception~~. ~~Except as provided in 33-22-706, the~~ The provisions of this part apply to all ~~group~~ policies and certificates of accident and health insurance and ~~group~~ subscriber contracts for the care and treatment of mental illness~~, alcoholism, and drug addiction~~ and chemical dependency offered to Montana residents by insurers, health service corporations, and all employees' health and welfare funds that provide accident and health insurance benefits to residents of this state. It is the purpose of this part to preserve the rights of the consumer to have this coverage according to the consumer's medical and economic needs."

{*Internal References to 33-22-701:*
*33-22-1521*x*}

Section 3. Section 33-22-702, MCA, is amended to read:

"33-22-702. Definitions. For purposes of this part, the following definitions apply:

~~(1) "Chemical dependency treatment center" means a treatment facility that:~~

~~(a) provides a program for the treatment of alcoholism or drug addiction pursuant to a written treatment plan approved and monitored by a physician or addiction counselor licensed by the state; and~~

~~(b) is licensed or approved as a treatment center by the department of public health and human services under 53-24-208 or is licensed or approved by the state where the facility is located.~~

~~(2) "Inpatient benefits" are as set forth in 33-22-705.~~

~~(3) "Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by an interdisciplinary team, including a licensed physician, psychiatric social worker, and psychologist, and a treatment facility that is:~~

~~(a) licensed as a mental health treatment center by the state;~~

~~(b) funded or eligible for funding under federal or state law; or~~

~~(c) affiliated with a hospital under a contractual agreement with an established system for patient referral.~~

~~(4)~~ (1) (a) "Mental ~~illness~~ health condition" means ~~a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:~~

~~(i) present distress or a painful symptom;~~

~~(ii) a disability or impairment in one or more areas of~~

~~functioning; or~~

~~(iii) a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.~~

~~(b) Mental illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.~~

~~(c) Mental illness does not include:~~

~~(i) a developmental disorder;~~

~~(ii) a speech disorder;~~

~~(iii) a psychoactive substance use disorder;~~

~~(iv) an eating disorder, except for bulimia and anorexia nervosa;~~

~~(v) an impulse control disorder, except for intermittent explosive disorder and trichotillomania; or~~

~~(vi) a severe mental illness as provided in 33-22-706~~ any condition or disorder involving mental illness or chemical dependency that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of disease.

~~(5) "Outpatient benefits" are as set forth in 33-22-705.~~

(2) "Rate, term, or condition means any lifetime or annual payment limits, deductibles, copayments, coinsurance, and any other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of health coverage that affects the insured."

{*Internal References to 33-22-702:*
33-22-706d *33-22-706 d* *33-22-1521*x*}

Section 4. Section 33-22-706, MCA, is amended to read:

"33-22-706. (Temporary) Coverage for ~~severe~~ mental ~~illness -- definition~~ health conditions. (1) Except as provided in 33-22-262(3) and subject to 33-22-262(4), a policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a scope and level of benefits for the necessary care and treatment of ~~severe~~ mental ~~illness, as defined in subsection (6),~~ health conditions that is no less favorable than that level provided for other physical illness generally and may not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required under a plan must be comprehensive for coverage of both mental health and physical health conditions. Benefits for treatment of ~~severe~~ mental ~~illness~~ health conditions may be subject to managed care provisions contained in the policy or certificate to the extent the provisions do not diminish or negate the purpose of this part.

(2) Benefits provided pursuant to subsection (1) include but are not limited to:

(a) inpatient ~~hospital~~ services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication; and

(e) services for mental health conditions rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, ~~or~~ licensed professional counselor, or licensed addictions counselor when those services are within the scope of practice of the licensed practitioner and are a part of a treatment plan ~~recommended and authorized by a licensed physician; and~~

~~(f) services rendered by a licensed advanced practice registered nurse with prescriptive authority and specializing in mental health~~.

~~(3) Benefits provided pursuant to this section must be included when determining maximum lifetime benefits, copayments, and deductibles.~~

~~(4)~~(3) (a) This section applies to health service benefits provided by:

(i) individual and group health and disability insurance;

(ii) individual and group hospital or medical expense insurance;

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation;

(v) health maintenance organizations; and

(vi) the comprehensive health association created by 33-22-1503.

(b) This section does not apply to the following coverages:

(i) blanket;

(ii) short-term travel;

(iii) accident only;

(iv) limited or specific disease;

(v) Title XVIII of the Social Security Act (medicare); or

(vi) any other similar coverage under state or federal government plans.

~~(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental illness, as defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.~~

~~(6) As used in this section, "severe mental illness" means the following disorders as defined by the American psychiatric association:~~

~~(a) schizophrenia;~~

~~(b) schizoaffective disorder;~~

~~(c) bipolar disorder;~~

~~(d) major depression;~~

~~(e) panic disorder;~~

~~(f) obsessive-compulsive disorder; and~~

~~(g) autism~~. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-22-706. (Effective July 1, 2009) Coverage for ~~severe~~ mental ~~illness -- definition~~ health conditions. (1) A policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of ~~severe~~ mental ~~illness, as defined in subsection (6),~~ health conditions that is no less favorable than

that level provided for other physical illness generally and may not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required under a plan must be comprehensive for coverage of both mental health and physical health conditions. Benefits for treatment of ~~severe~~ mental ~~illness~~ health conditions may be subject to managed care provisions contained in the policy or certificate to the extent the provisions do not diminish or negate the purpose of this part.

(2) Benefits provided pursuant to subsection (1) include but are not limited to:

(a) inpatient ~~hospital~~ services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication;

(e) services for mental health conditions rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, ~~or~~ licensed professional counselor, or licensed addictions counselor when those services are within the scope of practice of the licensed practitioner and are a part of a treatment plan ~~recommended and authorized by a licensed physician; and~~

~~(f) services rendered by a licensed advanced practice registered nurse with prescriptive authority and specializing in~~

~~mental health~~.

~~(3) Benefits provided pursuant to this section must be included when determining maximum lifetime benefits, copayments, and deductibles.~~

~~(4)~~ (3) (a) This section applies to health service benefits provided by:

(i) individual and group health and disability insurance;

(ii) individual and group hospital or medical expense insurance;

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation;

(v) health maintenance organizations; and

(vi) the comprehensive health association created by 33-22-1503.

(b) This section does not apply to the following coverages:

(i) blanket;

(ii) short-term travel;

(iii) accident only;

(iv) limited or specific disease;

(v) Title XVIII of the Social Security Act (medicare); or

(vi) any other similar coverage under state or federal government plans.

~~(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental illness, as defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.~~

~~(6) As used in this section, "severe mental illness" means~~

~~the following disorders as defined by the American psychiatric association:~~

~~(a) schizophrenia;~~

~~(b) schizoaffective disorder;~~

~~(c) bipolar disorder;~~

~~(d) major depression;~~

~~(e) panic disorder;~~

~~(f) obsessive-compulsive disorder; and~~

~~(g) autism.~~"

{*Internal References to 33-22-706:*
33-22-262 a *33-22-701 x* *33-22-702 s* *33-22-704r*
33-22-1521 x *33-31-111 x* *33-31-111x*}

Section 5. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 ~~(excepting 33-22-701 through 33-22-705)~~, and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) (a) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 50% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but the maximums may not be less than $100,000.

(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed $1,000 per person. This association plan must provide a maximum lifetime benefit of at least $500,000.

(c) Covered expenses for plans under subsection (1)(a) and (1)(b) must be paid as specified in provider contracts or, in the absence of a provider contract, at the prevailing charge in the state where the service is provided.

(d) The board may authorize other association plans, including managed care plans as defined in 33-36-103.

(2) Covered expenses for plans offered under subsections (1)(a) and (1)(b) must be for the following medically necessary services and articles when prescribed by a physician or other licensed health care professional and when designated in the contract:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental;

(l) services of a licensed home health agency, up to a maximum of 180 visits per year;

(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of the expense, up to an annual maximum of $2,000;

(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;

(o) pregnancy, including complications of pregnancy;

(p) newborn infant coverage, as required by 33-22-301;

(q) sterilization;

(r) immunizations;

(s) outpatient rehabilitation therapy;

(t) foot care for diabetics;

(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year;

(v) travel, other than transportation by a licensed

ambulance service, to the nearest facility qualified to treat the patients medical condition when approved in advance by the insurer; and

(w) coverage for ~~severe~~ mental ~~illness~~ health conditions as required in 33-22-706.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) home and office calls, except as specifically provided in subsection (2);

(ii) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(iii) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(iv) oral surgery, except as specifically provided in subsection (2);

(v) that part of a charge for services or articles that exceeds the prevailing charge in the state where the service is provided; or

(vi) care that is primarily for custodial or domiciliary purposes that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, except as provided by subsection (2);

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) room and board for a nonemergency admission on Friday or Saturday;

(vii) routine well baby care;

(viii) complications to a newborn, unless no other source of coverage is available;

(ix) reversal of sterilization;

(x) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xi) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xii) artificial insemination or treatment for infertility; or

(xiii) breast augmentation or reduction."

{*Internal References to 33-22-1521:*

33-22-245 x 33-22-522 x 33-22-1501 x 33-22-1501x
33-22-1511 x 33-22-1827x}

NEW SECTION. **Section 6. {standard} Repealer.** Sections 33-22-703, 33-22-704, and 33-22-705, MCA, are repealed.

{*Internal References to 33-22-703: 33-22-1521*x*
*Internal References to 33-22-704: 33-22-1521*x*
Internal References to 33-22-705: 33-22-702 d 33-22-702 d 33-22-1521a}

NEW SECTION. **Section 7. Applicability.** [This act] applies to any policy or certificate of health insurance or disability insurance offered or renewed on or after January 1, 2008.

- END -

{Name : Susan Byorth Fox
Title : Executive Director
Agency: Legislative Services Division
Phone : (406) 444-3066
E-Mail: sfox@mt.gov}