SENATE BILL NO. 366

INTRODUCED BY FRANKLIN, KENNEDY, PIPINICH, JACOBSON, BROOKE, HALLIGAN, YELLOWTAIL, DOHERTY, ECK, BRUSKI, MANNING, VAUGHN, HARDING, RUSSELL, CODY, WATERMAN, L. NELSON, HANSEN, S. RICE, BECKER, STRIZICH, MESSMORE, DARKO, BARNHART, HARRINGTON, BRADLEY, WYATT, REAM, COCCHIARELLA, KADAS, BIANCHI, CONNELLY

IN THE SENATE

FEBRUARY 13, 1991	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & INDUSTRY.
	FIRST READING.
FEBRUARY 19, 1991	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
FEBRUARY 20, 1991	PRINTING REPORT.
FEBRUARY 21, 1991	SECOND READING, DO PASS.
FEBRUARY 22, 1991	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 39; NOES, 11.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

MARCH 4, 1991	INTRODUCED AND REFERRED TO COMMITTEE ON HUMAN SERVICES & AGING.
	FIRST READING.
MARCH 23, 1991	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
APRIL 6, 1991	SECOND READING, CONCURRED IN.
	ON MOTION, RULES SUSPENDED. BILL PLACED ON THIRD READING THIS DAY.
	THIRD READING, CONCURRED IN. AYES, 68; NOES, 28.
	RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

APRIL 17, 1991	RECEIVED FROM HOUSE.
	SECOND READING, AMENDMENTS CONCURRED IN.
APRIL 18, 1991	THIRD READING, AMENDMENTS CONCURRED IN.
APRIL 19, 1991	SENT TO ENROLLING.
	REPORTED CORRECTLY ENROLLED.

Senate BILL NO. 366

INTRODUCED BY [illegible]

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING HEALTH INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS TRANSACTING BUSINESS IN THIS STATE TO PROVIDE COVERAGE FOR MINIMUM MAMMOGRAPHY EXAMINATIONS; AMENDING SECTIONS 33-31-102 AND 53-6-101, MCA; AND PROVIDING AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Coverage for mammography examinations.** (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 and that provides coverage for a family member of the insured or subscriber must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) These services are subject to the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establishes durational limits, dollar limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

Section 2. 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) "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:

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LC 1354/01

(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; and

(i) minimum mammography examination, as defined in [section 1]; and

~~(i)~~(j) treatment for phenylketonuria. "Treatment" means licensed professional medical services under the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels of phenylalanine and adequate nutritional status.

(2) "Commissioner" means the commissioner of insurance of the state of Montana.

(3) "Department of health" means the department of health and environmental sciences provided for in 2-15-2101.

(4) "Director" means the director of the department of health and environmental sciences provided for in 2-15-2101.

(5) "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.

(6) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is ent[illegible].

(7) "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.

(8) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(9) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers.

(10) "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.

(11) "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.

(12) "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.

(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 nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of his practice or any other person who is licensed or otherwise authorized in this state to furnish

health care services.

(14) "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 3. Section 53-6-101, MCA, is amended to read:

"53-6-101. Montana medicaid program -- authorization of services. (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended. The department of social and rehabilitation services shall administer the Montana medicaid program.

(2) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined in [section 1];

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

(h) services provided by physician assistants-certified within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(i) health services provided under a physician's orders by a public health department; and

(j) hospice care as defined in 42 U.S.C. 1396d(o).

(3) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 2;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital service persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23, if funds are specifically appropriated for the inclusion of these services in the Montana medicaid program;

(m) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(n) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(4) The department may implement, as provided for in Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(5) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(6) The services provided under this part may be only

those that are medically necessary and that are the most efficient and cost effective.

(7) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended.

(8) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(9) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program.

(10) Community-based medicaid services, as provided for in part 4 of this chapter, must be provided in accordance with the provisions of this chapter and the rules adopted thereunder. (Subsection (2)(j) terminates June 30, 1991--sec. 4, Ch. 633, L. 1989; Subsection (3)(m) terminates June 30, 1991--sec. 15, Ch. 649, L. 1989.)"

NEW SECTION. **Section 4.** **Applicability.** [Sections 1 and 2] apply to policies or contracts delivered or issued for delivery or renewed in this state on or after January 1, 1992.

NEW SECTION. **Section 5.** **Codification instruction.**

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

-End-

APPROVED BY COMM. ON
BUSINESS & INDUSTRY

SENATE BILL NO. 366

INTRODUCED BY FRANKLIN, KENNEDY, PIPINICH, JACOBSON, BROOKE, HALLIGAN, YELLOWTAIL, DOHERTY, ECK, BRUSKI, MANNING, VAUGHN, HARDING, RUSSELL, CODY, WATERMAN, L. NELSON, HANSEN, S. RICE, BECKER, STRIZICH, MESSMORE, DARKO, BARNHART, HARRINGTON, BRADLEY, WYATT, REAM, COCCHIARELLA, KADAS, BIANCHI, CONNELLY

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(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) These services are subject to the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establishes durational limits, ~~dollar limits,~~ deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally. A MINIMUM $50 LIMIT MUST BE MADE AVAILABLE FOR EACH OF THESE SERVICES.

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(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 nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of his practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

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(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

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(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 2;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

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for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

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NEW SECTION. **Section 4.** **Applicability.** [Sections 1 and 2] apply to policies or contracts delivered or issued for delivery or renewed in this state on or after January 1, 1992.

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THIRD READING

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(4) The department may implement, as provided for in Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended, a program under medicaid

for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(5) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(6) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost effective.

(7) The amount, scope, and duration of services provided under this part must be determined by the department in accordance with Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended.

(8) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(9) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program.

(10) Community-based medicaid services, as provided for in part 4 of this chapter, must be provided in accordance with the provisions of this chapter and the rules adopted thereunder. (Subsection (2)(j) terminates June 30,

1991--sec. 4, Ch. 633, L. 1989; Subsection (3)(m) terminates June 30, 1991--sec. 15, Ch. 649, L. 1989.)"

NEW SECTION. **Section 4. Applicability.** [Sections 1 and 2] apply to policies or contracts delivered or issued for delivery or renewed in this state on or after January 1, 1992.

NEW SECTION. **Section 5. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 1].

-End-

HOUSE STANDING COMMITTEE REPORT

March 23, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that Senate Bill 366 (third reading copy -- blue) be concurred in as amended .

Signed: Angela Russell
Angela Russell, Chairman

CARRIED BY REP RUSSELL

And, that such amendments read:
1. Page 2, lines 13 and 14.
Strike: "$50 LIMIT MUST BE MADE AVAILABLE FOR EACH OF THESE SERVICES"
Insert: "$70 payment must be made for each mammography examination performed"

HOUSE
SB 366

631028SC.Hpd

SENATE BILL NO. 366

INTRODUCED BY FRANKLIN, KENNEDY, PIPINICH, JACOBSON, BROOKE, HALLIGAN, YELLOWTAIL, DOHERTY, ECK, BRUSKI, MANNING, VAUGHN, HARDING, RUSSELL, CODY, WATERMAN, L. NELSON, HANSEN, S. RICE, BECKER, STRIZICH, MESSMORE, DARKO, BARNHART, HARRINGTON, BRADLEY, WYATT, REAM, COCCHIARELLA, KADAS, BIANCHI, CONNELLY

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING HEALTH INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS TRANSACTING BUSINESS IN THIS STATE TO PROVIDE COVERAGE FOR MINIMUM MAMMOGRAPHY EXAMINATIONS; AMENDING SECTIONS 33-31-102 AND 53-6-101, MCA; AND PROVIDING AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1.** **Coverage for mammography examinations.** (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 and that provides coverage for a family member of the insured or subscriber must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) These services are subject to the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establishes durational limits, ~~dollar limits,~~ deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally. A MINIMUM ~~$50 LIMIT--MUST BE MADE AVAILABLE FOR EACH OF THESE SERVICES~~ $70 PAYMENT MUST BE MADE FOR EACH MAMMOGRAPHY EXAMINATION PERFORMED.

Section 2. 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) "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; and

(i) minimum mammography examination, as defined in [section 1]; and

~~(i)~~(j) treatment for phenylketonuria. "Treatment" means licensed professional medical services under the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels of phenylalanine and adequate nutritional status.

(2) "Commissioner" means the commissioner of insurance of the state of Montana.

(3) "Department of health" means the department of health and environmental sciences provided for in 2-15-2101.

(4) "Director" means the director of the department of health and environmental sciences provided for in 2-15-2101.

(5) "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.

(6) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(7) "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.

(8) "Health care services agreement" means an agreement for health care services between a health maintenance

organization and an enrollee.

(9) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers.

(10) "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.

(11) "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.

(12) "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.

(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 nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of his practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

(14) "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 3. Section 53-6-101, MCA, is amended to read:

"**53-6-101. Montana medicaid program -- authorization of services.** (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended. The department of social and rehabilitation services shall administer the Montana medicaid program.

(2) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services, including minimum mammography examination as defined in [section 1];

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

(h) services provided by physician assistants-certified within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(i) health services provided under a physician's orders by a public health department; and

(j) hospice care as defined in 42 U.S.C. 1396d(o).

(3) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined

by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 2;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23, if funds are specifically appropriated for the inclusion of these services in the Montana medicaid program;

(m) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(n) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(4) The department may implement, as provided for in

Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(5) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

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(9) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program.

(10) Community-based medicaid services, as provided for in part 4 of this chapter, must be provided in accordance

with the provisions of this chapter and the rules adopted thereunder. (Subsection (2)(j) terminates June 30, 1991--sec. 4, Ch. 633, L. 1989; Subsection (3)(m) terminates June 30, 1991--sec. 15, Ch. 649, L. 1989.)"

NEW SECTION. **Section 4. Applicability.** [Sections 1 and 2] apply to policies or contracts delivered or issued for delivery or renewed in this state on or after January 1, 1992.

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-End-