House BILL NO. 515

INTRODUCED BY DJ

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING A MINIMUM MATERNITY BENEFIT IN GROUP OR INDIVIDUAL MEDICAL EXPENSE DISABILITY POLICIES, CERTIFICATES OF INSURANCE, MEMBERSHIP CONTRACTS, SUBSCRIBER CONTRACTS, HEALTH CARE SERVICES AGREEMENTS, THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION PLAN, AND THE MONTANA MEDICAID PROGRAM; AMENDING SECTIONS 33-22-101, 33-22-1521, 33-31-102, AND 53-6-101, MCA; AND PROVIDING AN APPLICABILITY DATE."

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

Section 1. Section 33-22-101, MCA, is amended to read:

"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, [section 2], 33-22-243, and 33-22-304, do not apply to or affect:

(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(2) any group or blanket policy;

(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance as:

(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

(4) reinsurance."

NEW SECTION. **Section 2. Mandatory maternity coverage.** (1) Each group or individual medical expense disability policy, certificate of insurance, membership contract, subscriber contract, or health care

services agreement that is delivered, issued for delivery, renewed, extended, or modified in this state that provides maternity coverage must provide minimum maternity inpatient and post-hospital care coverage as provided in subsection (2).

(2) (a) For the purposes of this section, "minimum maternity inpatient and post-hospital care" means:

(i) 48 hours of inpatient care after a vaginal birth; or

(ii) 96 hours of inpatient care after a cesarean birth.

(b) If the obstetrical and pediatric care providers and the mother determine that discharge before the expiration of the time periods provided in subsection (2)(a) is appropriate, then the mother and baby must be covered for a post-hospital visit approximately 48 hours after discharge by or a visit with a physician, physician assistant-certified, advanced practice registered nurse, or a registered nurse. The visit may be a home visit by the registered nurse, a physician's office visit, or a hospital clinic visit. The health professional seen by the mother and child must have at least 1 year of experience within the last 5 years in the emotional and physical assessment of both new mothers and babies, as well as a minimum of 18 hours of training in the management of lactation.

(3) The services required by subsection (1) are subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes durational limits consistent with this section, dollar limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies.

Section 3. 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 part 7), 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 $500,000.

(2) Covered expenses must be the usual and customary charges 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 physicians 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 $1,000;

(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; ~~and~~

(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) minimum maternity inpatient and post-hospital care as provided in [section 2].

(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 locality 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 either 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."

Section 4. 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;

(i) minimum mammography examination, as defined in 33-22-132; ~~and~~

(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.

(k) minimum maternity inpatient and post-hospital care as provided in [section 2].

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

(3) "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.

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

(5) "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.

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

(7) "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.

(8) "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.

(9) "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.

(10) "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.

(11) "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.

(12) "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 5. 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 public health and human 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 33-22-132;

(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) 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;

(i) targeted case management services, as authorized in 42 U.S.C. 1396n(g), for high-risk pregnant women;

(j) services that are 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;

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

(l) federally qualified health center services, as defined in 42 U.S.C. 1396d(l)(2); and

(m) minimum maternity inpatient and post-hospital care as provided in [section 2].

(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;

(m) hospice care, as defined in 42 U.S.C. 1396d(o);

(n) case management services as provided in 42 U.S.C. 1396d(a) and 1396n(g), including targeted case management services for the mentally ill;

(o) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility, as defined in 50-5-101, that is licensed in accordance with 50-5-201; and

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

(4) Services for persons qualifying for medicaid under the medically needy category of assistance as described in 53-6-131 may be more limited in amount, scope, and duration than services provided to others qualifying for assistance under the Montana medicaid program. The department is not required to provide all of the services listed in subsections (2) and (3) to persons qualifying for medicaid under the medically needy category of assistance.

(5) If waivers of federal law are granted by the secretary of the U.S. department of health and human services, the department of public health and human services may implement limited medicaid benefits, to be known as basic medicaid, for recipients who are eligible because they are receiving aid to families with dependent children as the specified caretaker relative of a dependent child under the FAIM project and for all adult recipients of medical assistance only who are covered under a group related to aid to families with dependent children. Basic medicaid benefits consist of all mandatory services listed in subsections (2)(a) through (2)(l) but may include those optional services listed in subsections (3)(a) through (3)(p) that the department in its discretion specifies by rule. The department, in exercising its discretion, may consider the amount of funds appropriated by the legislature for the FAIM project and whether the provision of a particular service is commonly covered by private health insurance plans. However, a recipient who is pregnant is entitled to full medicaid coverage.

(6) 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.

(7) 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.

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

(9) 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.

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

(11) 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.

(12) 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 under this chapter.

(13) Medicaid payment for personal-care facilities may not be made unless the department certifies to the director of the governor's office of budget and program planning that payment to this type of provider would, in the aggregate, be a cost-effective alternative to services otherwise provided."

NEW SECTION. **Section 6. Applicability.** [Sections 1 through 4] apply to group or individual medical expense disability policies, certificates of insurance, membership contracts, subscriber contracts, or health care services agreements that are delivered, issued for delivery, renewed, extended, or modified in this state after October 1, 1997.

NEW SECTION. **Section 7. Codification instruction.** [Section 2] 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 2].

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0515, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
A bill requiring a minimum maternity benefit in certain medical policies, certificates of insurance, membership contracts, subscriber contracts, health care service agreements, the Montana Comprehensive Health Association Plan and the Montana Medicaid program.

ASSUMPTIONS:
Department of Public Health and Human Services:
1. Assume 4,400 Medicaid births per year (based on 1995 level)
2. Approximately 90%, or 3,960 patients will go home earlier than 48 or 96 hours and will require and receive a visit. Post-delivery visits are currently covered under Medicaid, but are not generally used at this interval. It is assumed that this act would require the visit.
3. Approximately one-half of these women will have a home health visit at an average cost of $60/visit.
4. It is estimated that half of these women will have a doctor's visit at an average cost of $35.60/visit.
5. Seventy-five percent of the annual impact will be felt in FY98, while FY99 will be 100%.
6. Funding is based on 29.83% general fund in FY98 and 28.88% in FY99, with the complement being federal funds.

State Auditor's Office:
7. General fund revenue is based upon approximately 750 health care policies being amended. It is estimated that 50% will be updated with a $10 endorsement, and the other half with a $25 endorsement. This will be one-time fee revenue to the general fund in FY98.
8. The State Auditor's Office (SAO) will process these endorsements and rewritten policies with 200 hours of overtimes estimated at a cost of $5,400.
9. The SAO may receive an increase in complaints as a result of these policy changes, but will absorb the extra workload with existing staff.

FISCAL IMPACT:

Expenditures:

Public Health and Human Services:	FY98 Difference	FY99 Difference
Benefits	$142,000	$189,300
Funding:		
General Fund	$ 42,300	$ 54,700
Federal special	99,700	134,600
Total	$142,000	$189,300
State Auditor's Office:		
Personal services (01)	$5,400	
Revenue:		
Insurance fees (01)	$13,100	
Federal grants (03)	99,700	134,600
Net Impact on Fund Balance: (revenue minus expense)		
General fund (01)	($34,600)	($54,700)

Dave Lewis 2-17-97

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

JOHN COBB, PRIMARY SPONSOR DATE