SENATE BILL NO. 34

INTRODUCED BY NELSON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Coverage for minimum hospital stay following childbirth.** (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health benefit plan, as defined in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider.

(5) A health benefit plan must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.

Section 2. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions,

limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in [section 1];

~~(f)~~(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection ~~(3)(f)~~ (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

~~(g)~~(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

~~(h)~~(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

~~(i)~~(ii) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee may not be individually determined based on the status of the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer.

(8) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

NEW SECTION. **Section 3. Coverage for minimum hospital stay following childbirth.** (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) Each disability insurance plan or group disability insurance plan that is delivered, issued for delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health services corporation may

not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A membership contract that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient hospital care under subsection (2) unless the inpatient hospital care is determined to be medically necessary by the attending health care provider.

(5) A health service corporation must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subscribers regarding the coverage required by this section.

NEW SECTION. **Section 4. Codification instruction.** (1) [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].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and the provisions of Title 33, chapter 30, part 10, apply to [section 3].

NEW SECTION. **Section 5. Effective date.** [This act] is effective January 1, 1998.

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0034, as revised

DESCRIPTION OF PROPOSED LEGISLATION:
An act requiring insurance coverage for a minimum hospital stay following childbirth.

ASSUMPTIONS:
State Auditor's Office:

1. There are approximately 750 health care policies that will be amended. It is estimated that one-half of these policies will be updated with an endorsement at $10 per endorsement, and that the other half of these policies will be rewritten at $25 per policy. This will be a one-time fee and one-time revenue to the general fund in fiscal year 1998 estimated to be $13,125.
2. The State Auditor's Office will process these endorsements and rewritten policies through payment of an estimated 200 hours of staff overtime estimated at a cost of $5,428.
3. Complaints to the State Auditor's Policyholders Service Bureau may increase due to non-compliance of this bill by health insurance providers. This possible increase in complaints will be absorbed by existing staff.

Department of Public Health and Human Services (DPHHS):

4. The effective date of this bill will be January 1, 1998.
5. The state Medicaid program covers approximately 4,000 deliveries per year.
6. In fiscal year 1998, Medicaid will cover only 2,000 births due to the effective date of bill.
7. It is estimated that 10 percent of the delivery claims, 200 in fiscal year 1998 and 400 in fiscal year 1999, will include one extra hospital day.
8. Both the mother and child will stay an extra day. Therefore, the estimated number of covered days will be twice the number of claims estimated in assumption 7 (200 x 2 = 400 in fiscal year 1998 and 400 x 2 = 800 in fiscal year 1999).
9. The FMAP rates used for Medicaid funding are 29.83 percent general fund in fiscal year 1998 and 28.88 percent general fund in fiscal year 1999.
10. It is assumed that the average cost per day to Medicaid is $500. The total estimated cost to Medicaid is $200,000 (400 x $500, with $59,660 of that cost as general fund) in fiscal year 1998 and $400,000 (800 x $500, with $115,520 of that cost as general fund) in fiscal 1999. This cost will be a responsibility of the department due to the passage of federal legislation, and is not shown as a cost to this proposed legislation. This additional cost will be reflected in the Medicaid estimates for the department.

FISCAL IMPACT:

State Auditor's Office	FY98 Difference	FY99 Difference
Expenditures:		
Personal Services	5,428	0
Funding:		
General Fund (01)	5,428	0
Revenues:		
Policy endorsements (01)	13,125	0
Net Impact on Fund Balance: (Revenue minus expense)		
General fund (01)	7,697	0

Dave Lewis 1-14-97
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Linda Nelson 1-15-97
LINDA NELSON, PRIMARY SPONSOR DATE
Fiscal Note for SB0034, as revised

SB 34

TAKEN FROM TABLE IN COM ON PUBLIC HEALTH, WELFARE & SAFETY

SENATE BILL NO. 34

INTRODUCED BY NELSON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Coverage for minimum hospital stay following childbirth.** (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health benefit plan, as defined in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider.

(5) A health benefit plan must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.

Section 2. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions,

limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in [section 1];

~~(f)~~(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection ~~(3)(f)~~ (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

~~(g)~~(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

~~(h)~~(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

~~(i)~~(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee may not be individually determined based on the status of the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer.

(8) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

NEW SECTION. **Section 3. Coverage for minimum hospital stay following childbirth.** (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) Each disability insurance plan or group disability insurance plan that is delivered, issued for delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health services corporation may

not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A membership contract that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient hospital care under subsection (2) unless the inpatient hospital care is determined to be medically necessary by the attending health care provider.

(5) A health service corporation must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subscribers regarding the coverage required by this section.

NEW SECTION. **Section 4. Codification instruction.** (1) [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].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and the provisions of Title 33, chapter 30, part 10, apply to [section 3].

NEW SECTION. **Section 5. Effective date.** [This act] is effective January 1, 1998.

-END-

SENATE BILL NO. 34

INTRODUCED BY NELSON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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(3) A decision to shorten the length of inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health benefit plan, as defined in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider.

(5) A health benefit plan, AS DEFINED IN 33-22-243, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.

Section 2. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

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(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

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(ii) restrictions on the selection of primary or referral providers;

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(iv) out-of-pocket costs, including copayments and deductibles;

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(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

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~~(f)~~(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

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"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

~~(h)~~(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

~~(i)~~(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the

moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee may not be individually determined based on the status of the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer.

(8) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

~~NEW SECTION.~~ ~~**Section 3. Coverage for minimum hospital stay following childbirth.** (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.~~

~~(2) Each disability insurance plan or group disability insurance plan that is delivered, issued for delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.~~

~~(3) A decision to shorten the length of inpatient stay to less than that provided under subsection~~

~~(2) must be made by the attending health care provider and the mother. A health services corporation may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.~~

~~(4) A membership contract that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient hospital care under subsection (2) unless the inpatient hospital care is determined to be medically necessary by the attending health care provider.~~

~~(5) A health service corporation must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subscribers regarding the coverage required by this section.~~

NEW SECTION. **Section 3. Codification instruction.** ~~(1)~~ [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].

~~(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and the provisions of Title 33, chapter 30, part 10, apply to [section 3].~~

NEW SECTION. **Section 4. Effective date.** [This act] is effective January 1, 1998.

-END-

SENATE BILL NO. 34

INTRODUCED BY NELSON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO THIRD READING COPY (BLUE) FOR COMPLETE TEXT.

SENATE BILL NO. 34

INTRODUCED BY NELSON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE COVERAGE FOR A MINIMUM HOSPITAL STAY FOLLOWING CHILDBIRTH; AMENDING SECTION 33-31-301, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Coverage for minimum hospital stay following childbirth.** (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health benefit plan, as defined in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider.

(5) A health benefit plan, AS DEFINED IN 33-22-243, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.

Section 2. Section 33-31-301, MCA, is amended to read:

"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in [section 1];

~~(f)~~(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection ~~(3)(f)~~ (3)(g) do not apply to services for mental illness provided

under the Montana medicaid program as established in Title 53, chapter 6;

~~(g)~~(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

~~(h)~~(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

~~(i)~~(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the

moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee may not be individually determined based on the status of the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer.

(8) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

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~~(2) Each disability insurance plan or group disability insurance plan that is delivered, issued for delivery, renewed, extended, or modified in this state by a health service corporation that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.~~

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~~(5) A health service corporation must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, members, beneficiaries, insureds, or subscribers regarding the coverage required by this section.~~

NEW SECTION. **Section 3. Codification instruction.** ~~(1)~~ [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].

~~(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 30, part 10, and the provisions of Title 33, chapter 30, part 10, apply to [section 3].~~

NEW SECTION. **Section 4. Effective date.** [This act] is effective January 1, 1998.

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