HOUSE BILL NO. 43

INTRODUCED BY RHONDA KNUDSEN

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATING TO TELEMEDICINE; PROVIDING THAT A PREVIOUSLY ESTABLISHED PATIENT-HEALTH CARE PROVIDER RELATIONSHIP IS NOT REQUIRED TO RECEIVE SERVICES BY TELEMEDICINE; REVISING THE DEFINITION OF TELEMEDICINE; EXTENDING THE COVERAGE REQUIREMENT TO PUBLIC EMPLOYEE BENEFIT PLANS AND SELF-INSURED STUDENT HEALTH PLANS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 2-18-704, 20-25-1303, 20-25-1403, 33-22-138, AND 37-3-102, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

Section 1. Section 2-18-704, MCA, is amended to read:

"**2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must contain provisions that permit:

(a) the member of a group who retires from active service under the appropriate retirement provisions of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19, chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered employment to remain a member of the group until the member becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, unless the member is a participant in another group plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost;

(b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible

for equivalent insurance coverage as provided in subsection (1)(a);

(c) the surviving children of a member to remain members of the group as long as they are eligible for retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

(2) An insurance contract or plan issued under this part must contain the provisions of subsection (1) for remaining a member of the group and also must permit:

(a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);

(b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and

(c) continued membership in the group by anyone eligible under the provisions of this section, notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

(3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a member of the state's group plan until the legislator becomes eligible for medicare under the federal Health Insurance for the Aged Act if the legislator:

(i) terminates service in the legislature and is a vested member of a state retirement system provided by law; and

(ii) notifies the department of administration in writing within 90 days of the end of the legislator's legislative term.

(b) A former legislator may not remain a member of the group plan under the provisions of subsection (3)(a) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

(c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and subsequently terminates membership may not rejoin the group plan unless the person again serves as a legislator.

(4) (a) A state insurance contract or plan must contain provisions that permit continued membership in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues

to be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's choice to continue membership in the group plan.

(b) A former judge may not remain a member of the group plan under the provisions of this subsection (4) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or

(iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act.

(c) A judge who remains a member of the group under the provisions of this subsection (4) and subsequently terminates membership may not rejoin the group plan unless the person again serves in a position covered by the state's group plan.

(5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the full premium for coverage and for that of the person's covered dependents.

(6) An insurance contract or plan issued under this part that provides for the dispensing of prescription drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

(a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty to the member; and

(b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

(7) An insurance contract or plan issued under this part must include coverage for:

(a) treatment of inborn errors of metabolism, as provided for in 33-22-131; ~~and~~

(b) telemedicine services, as provided for in 33-22-138; and

~~(b)~~(c) therapies for Down syndrome, as provided in 33-22-139.

(8) (a) An insurance contract or plan issued under this part that provides coverage for an individual in a member's family must provide coverage for well-child care for children from the moment of birth through 7

years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the contract or plan.

(b) Coverage for well-child care under subsection (8)(a) must include:

(i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(ii) routine immunizations according to the schedule for immunization recommended by the immunization practice advisory committee of the U.S. department of health and human services.

(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit as provided for in this subsection (8).

(d) For purposes of this subsection (8):

(i) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(ii) "well-child care" means the services described in subsection (8)(b) and delivered by a physician or a health care professional supervised by a physician.

(9) Upon renewal, an insurance contract or plan issued under this part under which coverage of a dependent terminates at a specified age must continue to provide coverage for any dependent, as defined in the insurance contract or plan, until the dependent reaches 26 years of age. For insurance contracts or plans issued under this part, the premium charged for the additional coverage of a dependent, as defined in the insurance contract or plan, may be required to be paid by the insured and not by the employer.

(10) Prior to issuance of an insurance contract or plan under this part, written informational materials describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan member.

(11) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician and, in the case of a health maintenance organization, the primary care physician, in consultation with the patient to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

(12) (a) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes.

(b) Coverage must include a $250 benefit for a person each year for medically necessary and prescribed outpatient self-management training and education for the treatment of diabetes.

(c) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration, and glucagon emergency kits.

(d) Nothing in subsection (12)(a), (12)(b), or (12)(c) prohibits the state or the Montana university group benefit plans from providing a greater benefit or an alternative benefit of substantially equal value, in which case subsection (12)(a), (12)(b), or (12)(c), as appropriate, does not apply.

(e) Annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy.

(f) This subsection (12) does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies offered by the state or the Montana university system as benefits to employees, retirees, and their dependents.

(13) (a) The state employee group benefit plans and the Montana university system group benefits plans that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer firefighter dies within the course and scope of employment. Except as provided in subsection (13)(b), the continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this section must provide for the same level of benefits as is available to other members of the group. Premiums charged to a spouse or dependent under this section must be the same as premiums charged to other similarly situated members of the group. Dependent special enrollment must be allowed under the terms of the

insurance contract or plan. The provisions of this subsection (13)(a) are applicable to a spouse or dependent who is insured under a COBRA continuation provision.

(b) The state employee group benefit plans and the Montana university system group benefits plans subject to the provisions of subsection (13)(a) may discontinue or not renew the coverage of a spouse or dependent only if:

(i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms of the state employee group benefit plans and the Montana university system group benefits plans or if the plans have not received timely premium payments;

(ii) the spouse or dependent has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage; or

(iii) the state employee group benefit plans and the Montana university system group benefits plans are ceasing to offer coverage in accordance with applicable state law.

(14) The state employee group benefit plans and the Montana university system group benefits plans must comply with the provisions of 33-22-153.

(15) An insurance contract or plan issued under this part and a group benefits plan issued by the Montana university system must provide mental health coverage that meets the provisions of Title 33, chapter 22, part 7. (See compiler's comments for contingent termination of certain text.)"

Section 2. Section 20-25-1303, MCA, is amended to read:

"**20-25-1303. Duties of commissioner -- group benefits plans and employee premium levels not mandatory subjects for collective bargaining.** (1) The commissioner shall:

(a) design group benefits plans and establish premium levels for employees;

(b) establish specifications for bids and accept or reject bids for administering group benefits plans;

(c) negotiate and administer contracts for group benefits plans;

(d) prepare an annual report that:

(i) describes the group benefits plans being administered; and

(ii) details the historical and projected program costs and the status of reserve funds; and

(e) adopt policies for the conduct of business of the advisory committee and to carry out the

provisions of this part.

(2) (a) ~~The~~ Except as provided in subsection (2)(b), the provisions of Title 33 do not apply to the commissioner when exercising the duties provided for in this part.

(b) Group benefit plans designed under this part must include coverage for telemedicine services as provided in 33-22-138.

(3) The design or modification of group benefits plans and the establishment of employee premium levels are not mandatory subjects for collective bargaining under Title 39, chapter 31."

Section 3. Section 20-25-1403, MCA, is amended to read:

"**20-25-1403. Authorization to establish self-insured health plan for students -- requirements -- exemption.** (1) The commissioner may establish a self-insured student health plan for enrolled students of the system and their dependents, including students of a community college district. In developing a self-insured student health plan, the commissioner shall:

(a) maintain the plan on an actuarially sound basis;

(b) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the plan; and

(c) deposit all reserve funds, contributions and payments, interest earnings, and premiums paid to the plan. The deposits must be expended for claims under the plan and for the costs of administering the plan, including but not limited to the costs of hiring staff, consultants, actuaries, and auditors, purchasing necessary reinsurance, and repaying debts.

(2) Prior to the implementation of a self-insured student health plan, the commissioner shall consult with affected parties, including but not limited to the board of regents and representatives of enrolled students of the system.

(3) A self-insured student health plan developed under this part is not responsible for and may not cover any services or pay any expenses for which payment has been made or is due under an automobile, premises, or other private or public medical payment coverage plan or provision or under a workers' compensation plan or program, except when the other payor is required by federal law to be a payor of last resort. The term "services" includes but is not limited to all medical services, procedures, supplies, medications,

or other items or services provided to treat an injury or medical condition sustained by a member of the plan.

(4) The provisions of 20-25-1315 through 20-25-1320 apply to any self-insured student health plan developed under this part.

(5) (a) ~~The~~Except as provided in subsection (5)(b), the provisions of Title 33 do not apply to the commissioner when exercising the duties provided for in this part.

(b) A self-insured student health plan established under this part must include coverage for telemedicine services as provided in 33-22-138."

Section 4. Section 33-22-138, MCA, is amended to read:

"**33-22-138. Coverage for telemedicine services -- rulemaking.** (1) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for health care services must provide coverage for health care services provided by a health care provider or health care facility by means of telemedicine if the services are otherwise covered by the policy, certificate, contract, or agreement.

(2) Coverage under this section must be equivalent to the coverage for services that are provided in person by a health care provider or health care facility.

(3) Nothing in this section may be construed to require:

(a) a health insurance issuer to provide coverage for services that are not medically necessary, subject to the terms and conditions of the insured's policy; ~~or~~

(b) a health care provider to be physically present with a patient at the site where the patient is located unless the health care provider who is providing health care services by means of telemedicine determines that the presence of a health care provider is necessary; or

(c) except as provided in 50-46-310, a patient to have a previously established patient-provider relationship with a specific health care provider in order to receive health care services by means of telemedicine.

(4) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions. Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical services covered under the plan may not be imposed on the coverage for services provided by

means of telemedicine.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, specified disease, or long-term care policies.

(6) The commissioner may adopt rules necessary to implement the provisions of this section.

~~(6)~~(7) For the purposes of this section, the following definitions apply:

(a) "Health care facility" means a critical access hospital, hospice, hospital, long-term care facility, mental health center, outpatient center for primary care, or outpatient center for surgical services licensed pursuant to Title 50, chapter 5.

(b) "Health care provider" means an individual:

(i) licensed pursuant to Title 37, chapter 3, 4, 6, 7, 10, 11, 15, 17, 20, 22, 23, 24, 25, or 35;

(ii) licensed pursuant to Title 37, chapter 8, to practice as a registered professional nurse or as an advanced practice registered nurse;

(iii) certified by the American board of genetic counseling as a genetic counselor; or

(iv) certified by the national certification board for diabetes educators as a diabetes educator.

(c) "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed ~~at a later date~~ by a health care provider or health care facility ~~at a distant site~~ without the patient present in real time. ~~The term includes interactive audio, video, and data communication.~~

(d) (i) "Telemedicine" means the use of ~~interactive~~ audio, video, or other telecommunications technology or media, including audio-only communication, e-mail, and facsimile transmission, that is:

(A) used by a health care provider or health care facility to deliver health care services in real time or through the use of store-and-forward technology at a site other than the site where the patient is located; and

(B) delivered over a secure connection or in a manner that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq.

~~(ii) The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.~~

~~(iii)~~(ii) ~~The~~ For physicians providing written certification of a debilitating medical condition pursuant to 50-46-310, the term does not include ~~the use of audio-only telephone, e-mail, or facsimile transmissions~~ audio-

only communication unless the physician has previously established a physician-patient relationship through an in-person encounter."

Section 5. Section 37-3-102, MCA, is amended to read:

"**37-3-102. Definitions.** Unless the context requires otherwise, in this chapter, the following definitions apply:

(1) "ACGME" means the accreditation council for graduate medical education.

(2) "AOA" means the American osteopathic association.

(3) "Approved internship" means an internship training program of at least 1 year in a program that either is approved for intern training by the AOA or conforms to the standards for intern training established by the ACGME or successors. However, the board may, upon investigation, approve any other internship.

(4) "Approved medical school" means a school that either is accredited by the AOA or conforms to the education standards established by the LCME or the world health organization or successors for medical schools that meet standards established by the board by rule.

(5) "Approved residency" means a residency training program conforming to the standards for residency training established by the ACGME or successors or approved for residency training by the AOA.

(6) "Board" means the Montana state board of medical examiners provided for in 2-15-1731.

(7) "Community-integrated health care" means the provision of out-of-hospital medical services that an emergency care provider with an endorsement may provide as determined by board rule.

(8) "Department" means the department of labor and industry provided for in Title 2, chapter 15, part 17.

(9) "Emergency care provider" or "ECP" means a person licensed by the board, including but not limited to an emergency medical responder, an emergency medical technician, an advanced emergency medical technician, or a paramedic. An emergency care provider with an endorsement may provide community-integrated health care.

(10) "LCME" means the liaison committee on medical education.

(11) "Medical assistant" means an unlicensed allied health care worker who functions under the supervision of a physician, physician assistant, or podiatrist in a physician's or podiatrist's office and who

performs administrative and clinical tasks.

(12) "Physician" means a person who holds a degree as a doctor of medicine or doctor of osteopathy and who has a valid license to practice medicine or osteopathic medicine in this state.

(13) "Practice of medicine" means the diagnosis, treatment, or correction of or the attempt to or the holding of oneself out as being able to diagnose, treat, or correct human conditions, ailments, diseases, injuries, or infirmities, whether physical or mental, by any means, methods, devices, or instrumentalities, including electronic and technological means such as telemedicine. If a person who does not possess a license to practice medicine in this state under this chapter and who is not exempt from the licensing requirements of this chapter performs acts constituting the practice of medicine, the person is practicing medicine in violation of this chapter.

(14) ~~(a)~~ "Telemedicine" ~~means the practice of medicine using interactive electronic communications, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine typically involves the application of secure videoconferencing or store-and-forward technology, as defined~~ has the meaning provided in 33-22-138.

~~(b) The term does not mean an audio-only telephone conversation, an e-mail or instant messaging conversation, or a message sent by facsimile transmission.~~"

NEW SECTION. **Section 6. Effective date.** [This act] is effective January 1, 2022.

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