SENATE BILL NO. 221

INTRODUCED BY K. GILLAN

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT THE COMMISSIONER OF INSURANCE MAY WAIVE HEALTH MAINTENANCE ORGANIZATION REQUIREMENTS FOR ACCOUNTABLE CARE ORGANIZATIONS; EXPANDING RULEMAKING AUTHORITY OF THE COMMISSIONER OF INSURANCE; AND AMENDING SECTIONS 33-31-102, 33-31-201, AND 53-6-702, MCA."

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

Section 1. 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) "Accountable care organization" means a group of health care providers that are willing and capable of accepting accountability for the total cost and quality of care for a defined population.

~~(1)~~(2) "Affiliation period" means a period that, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective.

~~(2)~~(3) "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;

(j) outpatient self-management training and education for the treatment of diabetes along with certain diabetic equipment and supplies as provided in 33-22-129; and

(k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have the meanings provided for in 33-22-131.

~~(3)~~(4) "Commissioner" means the commissioner of insurance of the state of Montana.

~~(4)~~(5) "Dependent" has the meaning provided in 33-22-140.

~~(5)~~(6) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

~~(6)~~(7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

~~(7)~~(8) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

~~(8)~~(9) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

~~(9)~~(10) (a) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers. This subsection does not limit methods of provider payments made by health maintenance organizations.

(b) The term does not apply to a PACE organization or an accountable care organization that has received a waiver pursuant to 33-31-201.

~~(10)~~(11) "Insurance producer" means an individual or business entity appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

~~(11)~~(12) "PACE organization" means an organization, as defined in 42 CFR 460.6, that is authorized by the centers for medicare and medicaid services and the department of public health and human services to operate a program of all-inclusive care for the elderly.

~~(12)~~(13) "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.

~~(13)~~(14) "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.

~~(14)~~(15) "Point-of-service option" means a delivery system that permits an enrollee of a health maintenance organization to receive health care services from a provider who is, under the terms of the enrollee's contract for health care services with the health maintenance organization, not on the provider panel of the health maintenance organization.

~~(15)~~(16) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or advanced practice registered nurse, as specifically listed in 37-8-202, who treats any illness or injury within the scope and limitations of the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(16)~~(17) "Provider panel" means those providers with whom a health maintenance organization contracts to provide health care services to the health maintenance organization's enrollees.

~~(17)~~(18) "Purchaser" means the individual, employer, or other entity, but not the individual certificate holder in the case of group insurance, that enters into a health care services agreement.

~~(18)~~(19) "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 2. Section 33-31-201, MCA, is amended to read:

"33-31-201. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first obtains from the secretary of state a certificate of authority to transact business in this state as a foreign corporation under 35-1-1028.

(2) Each application of a health maintenance organization, whether separately licensed or not, for a certificate of authority must:

(a) be verified by an officer or authorized representative of the applicant;

(b) be in a form prescribed by the commissioner;

(c) contain:

(i) the applicant's name;

(ii) the location of the applicant's home office or principal office in the United States, if a foreign person;

(iii) the date of organization or incorporation;

(iv) the form of organization, including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors;

(v) the state or country of domicile; and

(vi) any additional information that the commissioner may reasonably require; and

(d) set forth the following information or be accompanied by the following documents, as applicable:

(i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents, certified by the public officer with whom the originals were filed in the state or country of domicile;

(ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the

applicant's internal affairs, certified by its secretary or other officer having custody of the documents;

(iii) a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(iv) a copy of any contract made or to be made between:

(A) any provider and the applicant; or

(B) any person listed in subsection (2)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

(v) the extent to which any of the following will be included in provider contracts and the form of any provisions that:

(A) limit a provider's ability to seek reimbursement for basic health care services or health care services from an enrollee;

(B) permit or require a provider to assume a financial risk in the health maintenance organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

(C) govern amending or terminating an agreement with a provider;

(vi) a financial statement showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this chapter.

(vii) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other source of funding;

(viii) a power of attorney executed by the applicant, on a form prescribed by the commissioner, appointing the commissioner, the commissioner's successors in office, and the commissioner's authorized deputies as the applicant's attorney to receive service of legal process issued against it in this state;

(ix) a statement reasonably describing the geographic service area or areas to be served, by county, including:

(A) a chart showing the number of primary and specialty care providers, with locations and service areas

by county;

(B) the method of handling emergency care, with the location of each emergency care facility; and

(C) the method of handling out-of-area services;

(x) a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

(xi) a description of the complaint procedures to be used as required under 33-31-303;

(xii) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under 33-31-222;

(xiii) a summary of the way in which administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed with the commissioner in accordance with the filing provisions of 33-31-301(2). However, this subsection does not deprive the health maintenance organization of its right to confidentiality of any proprietary information, and the commissioner may not disclose that proprietary information to any other person. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

(C) the method of payment, including any provisions for the administrator to participate in the profits or losses of the plan;

(D) the duration of the contract; and

(E) any provisions for modifying, terminating, or renewing the contract.

(xiv) a summary of all financial guaranties by providers, sponsors, affiliates, or parents within a holding company system or any other guaranties that are intended to ensure the financial success of the plan, including hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

(xv) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

(xvi) evidence that it can meet the requirement of 33-31-216(10); and

(xvii) any other information that the commissioner may reasonably require to make the determinations

required in 33-31-202.

(3) Each health maintenance organization shall file each substantial change, alteration, or amendment to the information submitted under subsection (2) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may, after notice and hearing, disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may adopt reasonable rules exempting from the filing requirements of this subsection those items that the commissioner considers unnecessary.

(4) An applicant or a health maintenance organization holding a certificate of authority shall file with the commissioner all contracts of reinsurance and any modifications to the contracts. An agreement between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A reinsurance agreement must remain in full force and effect for at least 90 days following written notice of cancellation by either party by certified mail to the commissioner.

(5) Each health maintenance organization shall maintain, at its administrative office and make available to the commissioner upon request executed copies of all provider contracts.

(6) The commissioner may adopt reasonable rules exempting an insurer or health service corporation operating a health maintenance organization as a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner under other laws and rules administered by the commissioner.

(7) (a) The commissioner may waive the requirements of this section for a PACE organization that has entered into a PACE program agreement pursuant to 42 U.S.C. 1396u-4.

(b) A request for waiver must be submitted in a form prescribed by the commissioner. The waiver application must be filed and approved annually. The annual renewal process must be completed by June 30 of each year.

(c) The factors that the commissioner may take into account when granting a waiver include but are not limited to the financial condition of the PACE organization, any consumer complaints against the PACE organization, and the length of time the PACE organization has been in business.

(d) The PACE organization shall submit an audited financial statement for the organization as a whole and a financial statement for the PACE program specifically with the initial waiver application and annually on

June 30. The commissioner may request additional information necessary to evaluate the waiver request.

(e) The waiver automatically expires if the certification of the PACE organization by the centers for medicare and medicaid services or the department of public health and human services expires or is terminated.

(f) The PACE organization shall notify the commissioner within 30 days if the centers for medicare and medicaid services takes adverse action or issues any warnings regarding the continuation of the PACE organization.

(8) (a) (i) The commissioner may waive the requirements of this section for an accountable care organization. Upon establishment of a medicare shared savings program pursuant to 42 U.S.C. 1395jjj, an accountable care organization shall demonstrate compliance with the program requirements in a manner determined by the commissioner.

(ii) The commissioner shall follow the medicare shared savings program structure in developing compliance criteria needed for obtaining a waiver.

(b) A request for waiver must be submitted in a form prescribed by the commissioner. The waiver application must be filed and approved every 3 years. The renewal process must be completed by June 30 of every third year.

(c) The factors that the commissioner may take into account when granting a waiver include but are not limited to the financial condition of the accountable care organization, any consumer complaints against the organization, and the length of time the organization has been in business.

(d) The accountable care organization shall submit an audited financial statement for the organization as a whole and a financial statement for the accountable care organization program specifically with the initial waiver application and annually by June 30. The commissioner may request additional information necessary to evaluate the waiver request.

(e) The waiver automatically expires if certification of the accountable care organization under the medicare shared savings program or the department of public health and human services expires or is terminated."

Section 3. Section 53-6-702, MCA, is amended to read:

"53-6-702. Definitions. As used in this part, the following definitions apply:

(1) "Department" means the department of public health and human services.

(2) "Health maintenance organization" means a health maintenance organization as defined in

33-31-102.

(3) (a) "Managed care community network" or "network" means an entity, other than a health maintenance organization, that provides or arranges for comprehensive physical or mental health care services under a contract with the department, that is reimbursed by a capitated rate or a fixed monetary amount for a specified time period with a risk of financial loss or a financial incentive to the entity, and that:

(i) contracts for an estimated annual value of $1 million or more of state and federal medicaid funds; or

(ii) operates statewide or covers 20% or more of the medicaid population.

(b) The term does not include a provider of health care services under a contract with the department on a fee-for-service basis or a PACE organization~~, as defined in 42 CFR 460.6,~~ or an accountable care organization, as defined in 33-31-102, that has received a waiver under 33-31-201.

(4) "Managed health care entity" or "entity" means a health maintenance organization or a managed care community network.

(5) "Program" means an element of the integrated health care system created by this part."

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