

HOUSE BILL NO. 489

INTRODUCED BY C. HUNTER

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A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING THE MONTANA HEALTH CARE DATABASE BOARD AND THE MONTANA HEALTH CARE DATABASE; ESTABLISHING REQUIREMENTS FOR SUBMISSION OF INFORMATION TO THE DATABASE; ESTABLISHING OVERSIGHT RESPONSIBILITIES AND RULEMAKING AUTHORITY FOR THE COMMISSIONER OF INSURANCE; REQUIRING PARTICIPATION OF HEALTH PLANS; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; PROVIDING AN APPROPRIATION; AMENDING SECTIONS 2-18-702, 33-31-111, 53-4-1104, AND 53-6-111, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

**NEW SECTION. Section 1. Legislative findings -- intent.** (1) The legislature finds that the increasing cost of health care services to individual consumers, businesses, and state and local government warrants review and evaluation of information related to health care services and costs. The legislature further finds that this review is best accomplished by collecting and analyzing information on the health care services that are provided to Montanans and on the payments made for those services. Analysis of the information will allow policymakers, health plans, health care providers, researchers, and consumers to make more informed decisions about controlling health care costs, judging the relative value of health care services, and using available health care resources.

(2) The intent of [sections 1 through 8] is to create the Montana health care database and a governing board to oversee collection and analysis of health care information. The purpose of the Montana health care database is to:

- (a) provide transparency regarding health care pricing and the quality and utilization of health care services as a means of promoting competition among health plans and accountability for health care providers;
- (b) allow consumers to take responsibility for managing their own health care costs by making information about the actual cost and quality of health care services more readily and widely available; and
- (c) create a comprehensive data set that shows actual health care costs and expenditures and that as a result:



- 1 (i) allows Montanans to identify areas of potentially wasteful health care spending and to gain insight into
- 2 ways to better manage the use of health care resources; and
- 3 (ii) gives health plans the ability to evaluate the health risk of the population as a whole and to more
- 4 accurately establish premiums for health insurance.

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6 **NEW SECTION. Section 2. Definitions.** As used in [sections 1 through 8], the following definitions

7 apply:

- 8 (1) "Board" means the Montana health care database board provided for in [section 4].
- 9 (2) "Board of directors" means the board of directors appointed as provided in [section 5] to oversee the
- 10 Montana health care database board.
- 11 (3) "Commissioner" means the commissioner of insurance for the state of Montana.
- 12 (4) "Database" means the Montana health care database provided for in [section 6].
- 13 (5) "Health plan" means:
- 14 (a) a health insurance issuer as defined in 33-22-140 that provides major medical insurance coverage;
- 15 (b) a state or local government group benefits plan provided pursuant to Title 2, chapter 18;
- 16 (c) a self-funded multiple employer welfare arrangement provided for in Title 33, chapter 35; and
- 17 (d) any other entity regulated by the commissioner that provides major medical insurance coverage.

18

19 **NEW SECTION. Section 3. Applicability.** [Sections 1 through 8] apply to health plans as defined in

20 [section 2] and to:

- 21 (1) a third-party administrator that administers claims for self-funded health plans and is licensed under
- 22 Title 33, chapter 17, part 6;
- 23 (2) the healthy Montana kids plan provided for in Title 53, chapter 4, part 11; and
- 24 (3) the medicaid program provided for in Title 53, chapter 6.

25

26 **NEW SECTION. Section 4. Montana health care database board -- duties.** (1) There is a Montana

27 health care database board that is subject to the supervision of the commissioner and is governed by a board

28 of directors appointed as provided in [section 5]. The board shall establish itself as a nonprofit corporation

29 pursuant to Title 35, chapter 2.

- 30 (2) The board shall:



- 1 (a) oversee development and use of the database provided for in [section 6];
- 2 (b) develop a plan of operation that includes procedures and criteria detailing the activities and duties  
3 assigned to the board under [sections 1 through 8];
- 4 (c) adopt bylaws for the regulation of its affairs and the conduct of its business;
- 5 (d) establish criteria for the selection of a vendor to create and maintain the database pursuant to the  
6 provisions of Title 18, chapter 4;
- 7 (e) contract with a vendor to collect, store, and distribute data according to specifications established  
8 by the board and administrative rules promulgated by the commissioner;
- 9 (f) establish requirements for submission of information to the database in a manner that is efficient and  
10 cost-effective for both the providers and users of the data;
- 11 (g) promote the availability of information to payers, health plans, health care providers, consumers, and  
12 other interested parties in order to support transparency of the information and to allow database users to:
- 13 (i) evaluate potential changes in health care delivery;
- 14 (ii) conduct risk analysis;
- 15 (iii) identify potential waste in the health care system;
- 16 (iv) identify areas of need in the health care system; and
- 17 (v) plan for better use of health care resources;
- 18 (h) establish policies to ensure the confidentiality and security of database information;
- 19 (i) publish reports on trends and variances in cost and payment of health care services;
- 20 (j) conduct public education activities to raise awareness of the availability of health care cost information  
21 and other data maintained in the database;
- 22 (k) consult on a regular basis with parties interested in the activities of the board, including but not limited  
23 to health plans, health care providers, and consumers;
- 24 (l) secure funding through private and government grants;
- 25 (m) ~~assess fees on users, if necessary; and~~
- 26 ~~(n)~~ keep an accurate accounting of all activities, receipts, and expenditures. The board shall annually  
27 submit to the commissioner and the governor a report containing this accounting, including the relevant financial  
28 records of the vendor selected to operate the database; and
- (n) conduct a yearly objective impact report on whether or not the APCD is producing the data necessary to fulfill the stated purposes related to quality of health care, cost trend and utilization, as well as whether information produced by the is improving the quality of care, moderating its cost, or supporting appropriate utilization of healthcare resources in Montana . This report shall be sent to the Governor and State Legislature.

29           (3) The board may hire staff as necessary to carry out the duties of this section and to accomplish the  
30 purposes of [sections 1 through 8].

1 (4) The board is subject to the public participation and open meeting requirements of Title 2, chapter 3,  
2 and laws implementing the public's right to know under Article II, section 9, of the Montana constitution.  
3

4 **NEW SECTION. Section 5. Board of directors -- appointment -- compensation.** (1) There is a board  
5 of directors of the Montana health care database board consisting of nine voting members and two nonvoting  
6 members.

7 (2) (a) The commissioner shall appoint as voting members:

8 (i) two representatives of health plans;

9 (ii) two health care providers; and

10 (iii) one representative of a health-related or consumer advocacy organization with significant experience  
11 in health care matters.

12 (b) The governor shall appoint as voting members:

13 (i) the state medicaid director or a designee of the director with experience and expertise in the state  
14 medicaid program;

15 (ii) the administrator of the state employee group benefits plan or a designee of the administrator with  
16 experience and expertise related to the benefits plan;

17 (iii) one health care provider; and

18 (iv) one representative of a health-related or consumer advocacy organization with significant experience  
19 in health care matters.

20 (3) (a) The commissioner shall appoint as a nonvoting member a representative of the commissioner's  
21 staff who has experience in health insurance and health care matters.

22 (b) The governor shall appoint as a nonvoting member a representative from the governor's staff who  
23 has experience in health care delivery systems.

24 (c) The nonvoting members shall participate in all meetings of the board of directors.

25 (4) Each member appointed under subsection (2) shall serve a 3-year term and may be reappointed.  
26 Appointments must be made in a manner that provides for staggered terms.

27 (5) (a) A vacancy must be filled in the same manner as regular appointments. The member appointed  
28 to fill the vacancy shall serve for the unexpired term to which the member is appointed and may be reappointed.

29 (b) If a member or nonvoting member is not actively participating in the duties of the board of directors  
30 as determined by the person who made the original appointment, the member may be replaced as provided in

1 subsection (5)(a).

2 (6) Each voting member has one vote.

3 (7) Compensation, including travel expenses, is as provided under 2-15-124, except that the expenses  
4 for members who are state employees must be paid by their respective offices.

5 (8) Initial appointments to the board of directors must be made at least 1 month prior to the first meeting  
6 of the board of directors.

7 (9) (a) The board of directors shall meet at least twice each year. The first meeting must be scheduled  
8 no later than June 2013.

9 (b) The cost of meetings of the board of directors must be paid by the database board.

10 (10) The board of directors shall oversee operations of the database board and may hire an executive  
11 director.

12 NEW SECTION. Section 6. Advisory Committee. A permanent Advisory Committee on Data  
Collection and Reporting will be established that includes, but is not limited to, two data analytic and data informatics  
experts and a national health care payer with extensive experience with APCDs in multiple jurisdictions. The  
purpose of the Advisory Committee is it to develop the APCD database, monitor data collection and create a data  
submission guide.

13 NEW SECTION. Section 76. Health care database. (1) (a) The database shall collect:

14 (i) claims information, including the amounts paid on the claims, from health plans, pharmacy benefit  
15 managers, third-party administrators, the state medicaid program, the healthy Montana kids plan, and other  
16 payers; and

17 (ii) other information determined by the board to be necessary to accomplish the purposes of the  
18 database as established in [sections 1 through 8] and in administrative rule.

19 (b) Health plans shall submit claims information at the time the database becomes operational.

20 (2) To the greatest extent possible, the board shall arrange for the collection of claims information from  
21 medicare, the federal employee health benefit plans, tricare, and the Indian health service.

22 (3) The board shall establish:

23 (a) the frequency with which claims information must be submitted, which shall be no more frequent  
than quarterly;

24 (b) the format in which the information must be submitted; and

25 (c) other requirements necessary to maintain the database in a way that promotes efficiency, eliminates

26 unnecessary burdens on the data suppliers and users, avoids duplicative data submission, and promotes to the  
fullest extent possible all uses of the

27 data that support the purpose of the database as established in [section 1].

28           (4) Data collection shall align with uniform and standard data specifications recognized by the APCD Council and AHIP to establish and maintain the database in a cost effective manner and to facilitate uniformity among various all payer claims databases of other states.

29           (5) Claims information submitted to the database is subject to all state and federal laws governing privacy of health care information and of trade secrets.

30           (56) The database must use unique patient and provider identifiers and a uniform coding system.

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2 **NEW SECTION. Section 87. Powers and duties of commissioner -- rulemaking.** The commissioner  
3 shall:

4 (1) adopt rules necessary to implement [sections 1 through 8], including but not limited to rules:

5 (a) ensuring the privacy and security of the information in the database according to all applicable laws;

6 and

7 (b) specifying the types and format of information to be submitted to the database;

8 ~~(2) approve or disapprove fees proposed by the board for the purpose of paying for the ongoing activities~~  
9 ~~of the board;~~

10 (3) approve or disapprove the plan of operation and bylaws proposed by the board, including the  
11 required promotional activities and the plan for access to database information;

12 (4) approve or disapprove the selection of and the contract with the database vendor, including the fees  
13 charged by the vendor; and

14 (5) investigate and refer for further action, if appropriate, complaints received from the public related to  
15 the activities of the board and of the database vendor.

16

17 **NEW SECTION. Section 98. Reporting requirements for health plans -- penalties.** (1) (a) A health  
18 plan shall provide the information required under [sections 1 through 8] and administrative rules implementing  
19 [sections 1 through 8] if the plan covers at least 5% of the lives covered by major medical health plans in  
20 Montana.

21 (b) A third-party administrator shall provide the information required under [sections 1 through 8] and  
22 administrative rules implementing [sections 1 through 8] if the third-party administrator:

23 (i) is licensed under Title 33, chapter 17, part 6; and

24 (ii) administers claims for at least 5% of the lives covered under self-funded health plans.

25 (2) A health plan or third-party administrator that fails to comply with the requirements of [sections 1  
26 through 8] is subject to a fine of up to \$5,000 per violation and may be prohibited from obtaining information  
27 maintained in the database.

28 (3) Fines collected under this section must be deposited in a state special revenue account to the credit  
29 of the commissioner's office and must be used to support the activities of the board and the database.

30

1            **NEW SECTION.** **Section 109.** **Duty to report claims data to health care database.** A health plan  
 as  
 2 defined in [section 2] that meets the requirements of [section 8] shall provide claims data to the Montana health  
 3 care database as required under [sections 1 through 8]. A health plan that fails to comply with the reporting  
 4 requirements is subject to the penalty provided for in [section 8].

5  
 6            **NEW SECTION.** **Section 110.** **Participation in Montana health care database.** Self-funded multiple  
 7 employer welfare arrangements are subject to [sections 1 through 8].

8  
 9            **Section 124.** Section 2-18-702, MCA, is amended to read:

10            **"2-18-702. Group insurance for public employees and officers.** (1) (a) Except as provided in  
 11 subsection (1)(c), all counties, cities, towns, school districts, and the board of regents shall upon approval by  
 12 two-thirds vote of their respective officers and employees enter into group hospitalization, medical, health,  
 13 including long-term disability, accident, or group life insurance contracts or plans for the benefit of their officers  
 14 and employees and their dependents. The laws prohibiting discrimination on the basis of marital status in Title  
 15 49 do not prohibit bona fide group insurance plans from providing greater or additional contributions for insurance  
 16 benefits to employees with dependents than to employees without dependents or with fewer dependents.

17            (b) The governing body of a county, city, or town may, at its discretion, consider the employees of  
 18 private, nonprofit economic development organizations, hospitals, health centers, or nursing homes to be  
 19 employees of the county, city, or town solely for the purpose of participation in group hospitalization, medical,  
 20 health, including long-term disability, accident, or group life insurance contracts or plans as provided in subsection  
 21 (1)(a). The governing body of the county, city, or town may require an employee, organization, hospital, health  
 22 center, or nursing home to pay the actual cost of coverage required for participation or may, at its discretion and  
 23 subject to any restriction on who may be a member of a group, pay all or part of the cost of coverage of the  
 24 employee of the organization.

25            (c) The governing body of a county having a taxable valuation of less than \$30 million or the board of  
 26 trustees of a hospital district may, at its discretion, exempt employees of a county hospital, county rest home or  
 27 nursing home, or hospital district from participation in group hospitalization, medical, health, including long-term  
 28 disability, accident, or group life insurance contracts or plans provided pursuant to subsection (1)(a) or (1)(b).

29            **(2) A group contract or plan for major medical coverage offered under this section must provide claims**  
 30 **information to the Montana health care database as required under [sections 1 through 8].**

1           ~~(2)~~(3) State employees and elected officials, as defined in 2-18-701, may participate in state employee  
2 group benefit plans as are provided for under part 8 of this chapter.

3           ~~(3)~~(4) For state officers and employees, the premiums required from time to time to maintain the  
4 insurance in force must be paid by the insured officers and employees, and the state treasurer shall deduct the  
5 premiums from the salary or wages of each officer or employee who elects to become insured, on the officer's  
6 or employee's written order, and issue a warrant for the premiums to the insurer.

7           ~~(4)~~(5) For the purpose of this section, the plans of health service corporations for defraying or assuming  
8 the cost of professional services of licensees in the field of health or the services of hospitals, clinics, or  
9 sanitariums or both professional and hospital services must be construed as group insurance and the dues  
10 payable under the plans must be construed as premiums for group insurance.

11           ~~(5)~~(6) If the board of trustees of a school district implements a self-insured group health plan or if the  
12 board of regents implements an alternative to conventional insurance to provide group benefits to its employees,  
13 the board shall maintain the alternative plan on an actuarially sound basis."  
14

15           **Section 1~~32~~**. Section 33-31-111, MCA, is amended to read:

16           **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided  
17 in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization  
18 authorized to transact business under this chapter. This provision does not apply to an insurer or health service  
19 corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state  
20 except with respect to its health maintenance organization activities authorized and regulated pursuant to this  
21 chapter.

22           (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its  
23 representatives is not a violation of any law relating to solicitation or advertising by health professionals.

24           (3) A health maintenance organization authorized under this chapter is not practicing medicine and is  
25 exempt from Title 37, chapter 3, relating to the practice of medicine.

26           (4) This chapter does not exempt a health maintenance organization from:

27           (a) [sections 1 through 8]; or

28           (b) the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

29           (5) This section does not exempt a health maintenance organization from the prohibition of pecuniary  
30 interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704.

1 A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701  
2 through 33-3-704.

3 (6) This section does not exempt a health maintenance organization from:

4 (a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

5 (b) the provisions of Title 33, chapter 22, part 19;

6 (c) the requirements of 33-22-134 and 33-22-135;

7 (d) network adequacy and quality assurance requirements provided under chapter 36; or

8 (e) the requirements of Title 33, chapter 18, part 9.

9 (7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212,  
10 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129,  
11 33-22-131, 33-22-136, 33-22-137, 33-22-141, 33-22-142, 33-22-152, 33-22-244, 33-22-246, 33-22-247,  
12 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance  
13 organizations."

14

15 **Section 143.** Section 53-4-1104, MCA, is amended to read:

16 **"53-4-1104. Healthy Montana kids plan.** (1) There is a healthy Montana kids plan that provides  
17 comprehensive health coverage to uninsured children who are residents of the state.

18 (2) The plan includes and coordinates access to health coverage for enrollees in the children's health  
19 insurance program and the Montana medicaid program.

20 (3) The department shall:

21 (a) administer the plan; and

22 (b) provide healthy Montana kids plan claims information to the Montana health care database as  
23 required under [sections 1 through 8].

24 (4) To the extent permitted by federal law, the department shall use the name of the plan on documents  
25 associated with programs described in subsection (2), including but not limited to advertising, brochures,  
26 applications, and membership cards.

27 (5) State funding of the plan is contingent upon the availability of federal matching funds through the  
28 children's health insurance program or the Montana medicaid program."

29

30 **Section 14.** Section 53-6-111, MCA, is amended to read:

1           **"53-6-111. Department charged with administration and supervision of medical assistance**  
 2 **program -- overpayment recovery -- sanctions for fraudulent and abusive activities -- adoption of rules.**

3 (1) The department of public health and human services may administer and supervise a vendor payment  
 4 program of medical assistance under the powers, duties, and functions provided in Title 53, chapter 2, and this  
 5 chapter and that is in compliance with Title XIX of the Social Security Act.

6           (2) The department shall provide Montana medicaid program claims information to the Montana health  
 7 care database as required under [sections 1 through 8].

8           ~~(2)~~(3) (a) The department is entitled to collect from a provider, and a provider is liable to the department  
 9 for:

10           (i) the amount of a payment under this part to which the provider was not entitled, regardless of whether  
 11 the incorrect payment was the result of department or provider error or other cause; and

12           (ii) the portion of any interim rate payment that exceeds the rate determined retrospectively by the  
 13 department for the rate period.

14           (b) In addition to the amount of overpayment recoverable under subsection ~~(2)(a)~~ (3)(a), the department  
 15 is entitled to interest on the amount of the overpayment at the rate specified in 31-1-106 from the date 30 days  
 16 after the date of mailing of notice of the overpayment by the department to the provider, except that interest  
 17 accrues from the date of the incorrect payment when the payment was obtained by fraud or abuse.

18           (c) The department may collect any amount described in subsection ~~(2)(a)~~ (3)(a) by:

19           (i) withholding current payments to offset the amount due;

20           (ii) applying methods and using a schedule mutually agreeable to the department and the provider; or

21           (iii) any other legal means.

22           (d) The department may suspend payments to a provider for disputed items pending resolution of a  
 23 dispute.

24           (e) The fact that a provider may have ceased providing services or items under the medical assistance  
 25 program, may no longer be in business, or may no longer operate a facility, practice, or business does not excuse  
 26 repayment under this subsection ~~(2)~~ (3).

27           ~~(3)~~(4) The department shall adopt rules establishing a system of sanctions applicable to providers who  
 28 engage in fraud and abuse. Subject to the definitions in 53-6-155, the department rules must include but are not  
 29 limited to specifications regarding the activities and conduct that constitute fraud and abuse.

30           ~~(4)~~(5) Subject to subsections ~~(5)~~ (6) and ~~(6)~~ (7), the sanctions imposed under rules adopted by the

1 department under subsection ~~(3)~~ (4) may include but are not limited to:

- 2 (a) required courses of education in the rules governing the medicaid program;  
 3 (b) suspension of participation in the program for a specified period of time;  
 4 (c) permanent termination of participation in the medical assistance program; and  
 5 (d) imposition of civil monetary penalties imposed under rules that specify the amount of penalties  
 6 applicable to a specific activity, act, or omission involving intentional or knowing violation of specified standards.

7 ~~(5)~~(6) In all cases in which the department may recover medicaid payments or impose a sanction, a  
 8 provider is entitled to a hearing under the provisions of Title 2, chapter 4, part 6. This section does not require  
 9 that the hearing under Title 2, chapter 4, part 6, be granted prior to recovery of overpayment.

10 ~~(6)~~(7) The remedies provided by this section are separate and cumulative to any other administrative,  
 11 civil, or criminal remedies available under state or federal law, regulation, rule, or policy."  
 12

13 **NEW SECTION. Section 165. Appropriation.** (1) There is appropriated from the general fund to the  
 14 state auditor's office \$1.7 million for the biennium beginning July 1, 2013, to establish and operate the Montana  
 15 health care database board and the Montana health care database.

16 (2) IF THE HEALTH CARE DATABASE BOARD RECEIVES PRIVATE OR FEDERAL GRANTS AS ALLOWED UNDER  
 17 [SECTION 4], THE GENERAL FUND APPROPRIATION IS DECREASED IN ACCORDANCE WITH THE PROVISIONS OF 17-2-108.  
 18

19 **NEW SECTION. Section 176. Codification instruction.** (1) [Sections 1 through 8] are intended to be  
 20 codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [sections 1  
 21 through 8].

22 (2) [Section 9] is intended to be codified as an integral part of Title 33, chapter 1, part 1, and the  
 23 provisions of Title 33, chapter 1, apply to [section 9].

24 (3) [Section 10] is intended to be codified as an integral part of Title 33, chapter 35, part 3, and the  
 25 provisions of Title 33, chapter 35, apply to [section 10].  
 26

27 **NEW SECTION. Section 187. Effective date.** [This act] is effective July 1, 2013.  
 28

- END -