SENATE BILL NO. 422

INTRODUCED BY D. GRIMES

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING DEFINITIONS APPLICABLE TO MANAGED CARE PLAN NETWORKS; AMENDING SECTION 33-36-103, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Section 33-36-103, MCA, is amended to read:

"33-36-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Choice-of-benefit plan" means a health benefit plan that:

(a) allows a covered person the discretion to choose, at the point of service, a participating provider from within the network or a provider from outside the network; and

(b) does not require a covered person to use only a participating provider to provide health care services under the terms of the plan.

~~(1)~~(2) "Closed plan" means a ~~managed care~~ health benefit plan that requires covered persons to use only participating providers to provide health care services under the terms of the ~~managed care~~ plan.

~~(2)~~(3) "Combination plan" means ~~an open plan with a closed component~~ a health benefit plan with both of the following components:

(a) an open component that allows a covered person the discretion to choose, at the point of service, a participating provider from within the network or a provider from outside the network; and

(b) a closed component that requires a covered person to use only a participating provider to provide a particular health care service in accordance with the terms of the plan.

~~(3)~~(4) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

~~(4)~~(5) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating in a health benefit plan.

~~(5)~~(6) "Department" means the department of public health and human services established in 2-15-2201.

~~(6)~~(7) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

~~(7)~~(8) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

~~(8)~~(9) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

~~(9)~~(10) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

~~(10)~~(11) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

~~(11)~~(12) "Health care provider" or "provider" means a health care professional or a facility.

~~(12)~~(13) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

~~(13)~~(14) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.

~~(14)~~(15) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

~~(15)~~(16) "Managed care plan" means a ~~health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under~~

~~contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment~~ closed plan or combination plan. The term does not include a choice-of-benefit plan, preferred provider organization, or other provider network operated in a fee-for-service indemnity environment.

~~(16)~~(17) "Medically necessary" means services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a covered person's illness, injury, or medical condition according to accepted standards of medical practice and that are not provided only as a convenience.

~~(17)~~(18) "Network" means the group of participating providers that provides health care services to a managed care plan.

~~(18) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.~~

(19) "Participating provider" means a provider who, under a contract with a health carrier or with the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(20) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health care services rendered to the covered person.

(21) "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations.

(22) "Quality assurance" means quality assessment and quality improvement.

(23) "Quality improvement" means an effort to improve the processes and outcomes related to the provision of health care services within a health plan."

NEW SECTION. **Section 2. Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 3. Effective date.** [This act] is effective on passage and approval.

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