SENATE BILL NO. 148

INTRODUCED BY C. SQUIRES

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT CLARIFYING THE DETAIL RELATED TO THE EXPLANATION OF CHARGES THAT AN INSURER, HEALTH SERVICE ORGANIZATION, OR HEALTH MAINTENANCE ORGANIZATION THAT ISSUES POLICIES, CERTIFICATES, MEMBERSHIP CONTRACTS, OR SUBSCRIBER CONTRACTS LIMITING PAYMENT OF HEALTH CARE SERVICES BASED ON A USUAL, CUSTOMARY, AND REASONABLE STANDARD IS REQUIRED TO PROVIDE TO AN INDIVIDUAL WHO APPLIES FOR INSURANCE COVERAGE; DEFINING "USUAL, CUSTOMARY, AND REASONABLE"; AMENDING SECTION 33-15-308, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

Section 1. Section 33-15-308, MCA, is amended to read:

"33-15-308. Explanation of charges -- usual, customary, and reasonable standard defined. (1) An insurer, health service corporation, or health maintenance organization that issues policies, certificates, membership contracts, or subscriber contracts for delivery in this state ~~on or after January 1, 2000,~~ and that limits payment of health care services based on standards described as usual, ~~and~~ customary, and reasonable ~~and customary, prevailing fee, allowable charges, a relative value schedule, or other comparable terms~~ shall include~~,~~ and conspicuously display ~~displayed~~ in ~~the schedule page~~ any document summarizing coverage or elsewhere in the policy, certificate, membership contract, or subscriber contract:

~~(1)~~(a) a definition of the term or terms and an explanation of how the limitation of payment based on the term or terms is derived;

~~(2)~~(b) ~~if the standard of the term or terms is derived by the use of a database,~~ a description of ~~the~~ any database ~~reasonably calculated to inform the insured or certificate holder of the method used to define~~ used to calculate the usual, customary, and reasonable payment and a description of the geographic area or ~~demographic area from which the data~~ demographics contained in the database that are used to determine the ~~term or terms is derived~~ usual, customary, and reasonable payment; and

~~(3)~~(c) a statement informing the insured that the ~~insured's health care provider may charge more than the limits established by the defined terms and that the additional charges may not be covered by the policy,~~

~~certificate, membership contract, or subscriber contract~~ insurer's usual, customary, and reasonable payment may be less than the actual charges billed by the health care provider and that the insured may be responsible for any unpaid balance owing to the provider.

(2) The information required in subsections (1)(a) through (1)(c) must be provided to the individual at the time of application.

(3) An insurer may use only one type of usual, customary, and reasonable standard for a particular insurance product. The standard must be consistently applied to all individuals covered under that product. This subsection does not prohibit an insurer from negotiating claims with providers on a case-by-case basis if the outcome benefits the insured individual.

(4) An insurer shall provide to the commissioner any information that the commissioner may request regarding the calculation and payment of a usual, customary, and reasonable claim within 10 working days from receipt of the request. The information must be treated as confidential if the commissioner determines that privacy protections available under state law are applicable.

(5) As used in this section, "usual, customary, and reasonable" means any standard that is used to define payment of a health care services claim, including but not limited to terms such as "usual and customary", "reasonable and customary", "prevailing fee", "allowable charges", "a relative value schedule", and "relative based reimbursement value system"."

NEW SECTION. **Section 2. Effective date.** [This act] is effective January 1, 2004.

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