HOUSE BILL NO. 582

INTRODUCED BY A. WITTICH

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE CATASTROPHIC HEALTH CARE COSTS ACT TO ESTABLISH A STATE-FUNDED PROGRAM OF COVERAGE FOR CATASTROPHIC HEALTH CARE COSTS FOR LOW-INCOME ADULTS; ESTABLISHING PROCEDURES FOR REIMBURSEMENT OF CATASTROPHIC HEALTH CARE COSTS; REQUIRING STUDIES OF HEALTH CARE GAPS AND HEALTH CARE COSTS; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; PROVIDING APPROPRIATIONS; AMENDING SECTION 33-2-708, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Legislative findings -- purpose.** (1) The legislature finds that each individual, to the maximum extent possible, is responsible for the individual's own medical care and the medical care of the individual's dependents and to that end is encouraged to purchase health insurance with coverage sufficient to prevent the need for requesting public assistance under [sections 1 through 8].

(2) To safeguard the public health, safety, and welfare of Montanans, it is the purpose of [sections 1 through 8] to ensure that:

(a) low-income adults who have no other source of coverage for or payment of health care costs are not denied medical care or bankrupted to pay high medical bills when facing unexpected, catastrophic health care conditions; and

(b) health care providers receive assistance with the costs of uncompensated medical care.

(3) The legislature further finds that the catastrophic health care cost program established pursuant to [sections 1 through 8] is the payer of last resort for medically indigent individuals. Health care providers seeking reimbursement under the program are subject to the limitations and requirements established in [sections 1 through 8].

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

(1) "Catastrophic health care costs" means the cost of necessary medical services provided in Montana

to a medically indigent individual for:

(a) treatment costs related to a diagnosis of cancer; or

(b) an episode of care ~~that results in an individual's hospitalization~~ AS PROVIDED IN THIS PART.

(2) "CRITICAL ACCESS HOSPITAL" HAS THE MEANING PROVIDED IN 50-5-101.

(3) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES PROVIDED FOR IN 2-15-2201.

~~(2)~~(4) "Episode of care" means INPATIENT OR OUTPATIENT surgical or medical care provided in a hospital for a traumatic injury, an acute medical condition, or an acute worsening of a chronic medical condition.

~~(3)~~(5) "Health care provider" means:

(a) a hospital ~~as defined in 50-5-101~~ OR CRITICAL ACCESS HOSPITAL; or

(b) an individual health care provider who has provided health care services in a hospital setting and who is independent of, contracted to, or employed by the hospital.

(6) "HOSPITAL" HAS THE MEANING PROVIDED IN 50-5-101.

~~(4)~~(7) "Medical claim" means the itemized statements and standard forms used by health care providers to satisfy centers for medicare and medicaid services claims submission requirements.

~~(5)~~(8) "Medically indigent individual" means an individual who is unable to pay for the costs of medical care because the individual meets the eligibility standards established in [section 5].

~~(6)~~(9) (a) "Necessary medical services" means health care services and supplies that:

(i) a health care provider, exercising prudent clinical judgment, provides to a person for the purpose of treating cancer or for an episode of care ~~that results in hospitalization~~ REQUIRING INPATIENT OR OUTPATIENT HOSPITAL SERVICES;

(ii) are in accordance with generally accepted standards of medical practice;

(iii) are clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the person's cancer diagnosis or episode of care;

(iv) are not provided primarily for the convenience of the person or health care provider; and

(v) are the most cost-effective service or sequence of services or supplies and are at least as likely as other services or supplies to produce equivalent therapeutic or diagnostic results for the person's cancer diagnosis or episode of care.

(b) The term does not include ~~the following:~~ ANY HEALTH CARE SERVICE OR PROCEDURE NOT COVERED BY THE MONTANA MEDICAID PROGRAM PROVIDED FOR IN TITLE 53, CHAPTER 6, PART 1.

~~(i) bone marrow transplants;~~

~~(ii) organ transplants;~~

~~(iii) elective, cosmetic, or experimental procedures;~~

~~(iv) services related to or provided by residential, skilled nursing, assisted living, or shelter care facilities;~~

~~(v) services provided by or available to a patient from a state, federal, or local health program;~~

~~(vi) a drug, device, or procedure primarily utilized for weight reduction and complications directly related to the drug, device, or procedure; or~~

~~(vii) surgical or medical procedures that occur outside of Montana.~~

~~(7)~~(10) (a) "Resident" means a person ~~with a home, house, place of abode, place of habitation, dwelling, or place where the person actually~~ WHO HAS lived for a period of 6 consecutive months or more within this state.

(b) The term does not include a person who comes into this state for temporary purposes, including but not limited to education, vacation, or seasonal labor.

(c) Entry into active military duty does not change a person's residence for the purposes of [sections 1 through 8].

~~(8)~~(11) "Third-party insurance" means casualty insurance, disability insurance, health insurance, life insurance, marine and transportation insurance, motor vehicle insurance, property insurance, or any other insurance coverage under Title 33.

NEW SECTION. **Section 3. Catastrophic health care cost program -- duties of department.** (1) The department shall operate a catastrophic health care cost program to reimburse health care providers for catastrophic health care costs of medically indigent individuals AS PROVIDED IN THIS SECTION.

(2) THE PROGRAM SHALL REIMBURSE A HEALTH CARE PROVIDER OTHER THAN A CRITICAL ACCESS HOSPITAL if the aggregate costs of the care for an individual's treatment for cancer or for an episode of care exceed $10,000 a year~~. The program~~ AND shall reimburse ~~health care providers~~ only for the portion of the costs that exceeded $10,000.

(3) THE PROGRAM SHALL REIMBURSE CRITICAL ACCESS HOSPITALS FOR A MAXIMUM OF 50% OF THE CHARITY CARE PROVIDED TO MEDICALLY INDIGENT INDIVIDUALS DURING A CALENDAR YEAR, ACCORDING TO THE REIMBURSEMENT SCHEDULE PROVIDED FOR IN THIS SECTION.

~~(2)~~(4) The department shall:

(a) establish application, review, and reimbursement policies and procedures for the program;

(b) determine whether individuals who have received necessary medical services are medically indigent or eligible for other programs that would assist in the payment of health care costs;

(c) determine reimbursement rates for health care providers for necessary medical services that have resulted in catastrophic health care costs using a formula that:

(i) does not reimburse for medical claims that exceed the medicare-allowable charges for the same services;

(ii) prorates payments based on the amount of money available for the program and the amount of claims submitted; and

(iii) allocates the available annual funding into equal portions to make reimbursements on a semiannual basis; and

(d) contract with a third-party administrator to operate the program.

~~(3)~~(5) Reimbursement rates established by the department may not exceed:

(a) the usual, reasonable, and customary charges for the area in which the services were provided; or

(b) annual funding for the program. Money in excess of requests for reimbursement must revert to the general fund.

~~(4)~~(6) The department shall establish auditing procedures to ensure the accuracy of the medical claims submitted.

NEW SECTION. **Section 4. Administration of the program.** The third-party administrator under contract with the department shall:

(1) review claims and reimburse health care providers for catastrophic health care costs according to the reimbursement schedule established by the department; and

(2) report annually to the governor, the attorney general, and the legislature, as provided in 5-11-210, on:

(a) the number of claims for reimbursement submitted, denied, and approved by geographic region and by category of care;

(b) the total and average amounts spent on reimbursement by geographic area and by category of care; and

(c) the reason for denial of applications for reimbursement, including the number of individuals who were determined to be nonresidents or to be eligible for medicaid or premium assistance for the purchase of a qualified

health plan in the federally facilitated marketplace operated by the U.S. department of health and human services pursuant to 42 U.S.C. 18041.

NEW SECTION. **Section 5. Medically indigent individuals -- eligibility requirements.** (1) An individual without dependent children is medically indigent for the purposes of [sections 1 through 8] if the individual:

(a) is between the ages of 18 and 65;

(b) has a household income AT OR below 100% of the federal poverty level;

(c) is not eligible for the Montana medicaid program provided for in Title 53, chapter 6, part 1;

(d) is not eligible to receive premium assistance for the purchase of a qualified health plan as allowed under Public Law 111-148 and Public Law 11-152 and related federal regulations; and

(e) has ~~a combination of~~ income ~~and resources~~ insufficient to pay catastrophic health care costs over a period of 5 years, beginning on the date that necessary medical services were provided for a diagnosis of cancer or an episode of care that resulted in hospitalization.

(2) In determining an individual's income for the purposes of this section, the department shall include as income any income required to be reported as income on a federal individual income tax return.

~~(3) Resources include all property in which the individual may have an interest, whether tangible or intangible, real or personal, liquid or nonliquid, or pending, except the following:~~

~~(a) the individual's home;~~

~~(b) a value not exceeding $750 for a single item or $7,500 total value for any:~~

~~(i) household furnishings, goods, and appliances;~~

~~(ii) clothes, books, and musical instruments; and~~

~~(iii) family portraits or heirlooms of sentimental value to the individual;~~

~~(c) jewelry up to a total maximum value of $1,000;~~

~~(d) professional books, business equipment, or tools up to a total maximum value of $2,500; and~~

~~(e) a vehicle with a maximum value of $7,000.~~

NEW SECTION. **Section 6. Applications for reimbursement of catastrophic health care costs -- consent -- confidentiality.** (1) A health care provider OTHER THAN A CRITICAL ACCESS HOSPITAL shall submit claims to the third-party administrator for reimbursement of catastrophic health care costs that exceed $10,000 for a

medically indigent individual's cancer treatment or episode of care resulting in ~~hospitalization.~~ INPATIENT OR OUTPATIENT HOSPITAL CARE.

(2) A CRITICAL ACCESS HOSPITAL SHALL SUBMIT THE TOTAL AMOUNT OF CHARITY CARE PROVIDED DURING THE PREVIOUS 6 MONTHS. THE DEPARTMENT MAY REIMBURSE A MAXIMUM OF 50% OF THE CHARITY CARE IN ACCORDANCE WITH [SECTION 3].

(3) Claims must be submitted according to procedures established by the department by rule if the patient to whom necessary medical services were provided consents to:

(a) have the patient's medical claims shared for the purposes of [sections 1 through 8]; and

(b) provide the department with income and resource information necessary to determine eligibility under [section 5].

~~(2)~~(4) A claim submitted for reimbursement must include:

(a) all medical claims relevant to the necessary medical services that were provided, in accordance with procedures established by the department by rule;

(b) information indicating why the individual who received the medical services is considered to be medically indigent; and

(c) the consent form provided for in subsection (4).

~~(3)~~(5) (a) If the third-party administrator believes, based on its review of the information, that an individual may be medically indigent, the third-party administrator shall notify the department. The department shall contact the individual to obtain the income ~~and resource~~ information necessary to determine whether the individual meets the eligibility requirements of [section 5].

(b) If the department determines the individual is not medically indigent but may qualify for other types of assistance with health care costs or the purchase of health insurance, the department shall provide the individual with appropriate information on applying for the assistance.

~~(4)~~(6) The individual to whom necessary medical services were provided shall sign a form acknowledging that the patient:

(a) is aware that the health care provider is seeking reimbursement for catastrophic health care costs;

(b) consents to review of the individual's income ~~and resource~~ information and to review of the medical claims necessary to determine reimbursement under [sections 1 through 8]; and

(c) consents to review of the individual's medical records related to the catastrophic health care costs if the information is requested as part of an audit.

~~(5)~~(7) A health care provider OTHER THAN A CRITICAL ACCESS HOSPITAL shall submit an application for each episode of care that results in a medically indigent individual's ~~hospitalization. A health care provider~~ TREATMENT IN A HOSPITAL BUT is not required to submit separate applications for each necessary medical service provided to a medically indigent individual who is receiving ongoing treatment for a cancer diagnosis or episode of care but must submit a treatment plan at least semiannually if treatment extends beyond 6 months.

~~(6)~~(8) The third-party administrator shall make reimbursements twice a year according to the reimbursement schedule established by the department.

~~(7)~~(9) Failure by the health care provider or the individual to provide the information required under this section within the time periods established by the department must result in denial of reimbursement.

~~(8)~~(10) Medical records provided under this section are confidential health care information and may be used only for the purpose of determining whether the services provided were necessary medical services for which a health care provider may be reimbursed. The department shall establish procedures for ensuring confidentiality of the records.

NEW SECTION. **Section 7. Rulemaking authority.** The department shall adopt rules that may include but are not limited to:

(1) procedures for health care providers to use in applying for reimbursement of catastrophic health care costs;

(2) the reimbursement schedule for catastrophic health care claims;

(3) the procedure for reviewing medical claims to determine whether the medical services provided were necessary medical services;

(4) procedures for determining whether an individual is medically indigent;

(5) the consent form required under [section 6];

(6) the medical claims required to determine reimbursement;

(7) the auditing process to ensure the accuracy of the medical claims submitted; and

(8) the procedures for protecting the confidentiality of medical claims submitted as required under [sections 1 through 9] and any medical records requested as part of an audit.

NEW SECTION. **Section 8. Special revenue account.** (1) There is an account in the state special revenue fund to the credit of the department for the catastrophic health care cost program. Money must be

deposited in the account as provided in 33-2-708(3)(c). Interest and any other income earned on the account must be deposited in the account.

(2) Money in the account must be used to reimburse health care providers for catastrophic health care costs for medically indigent individuals as provided in [sections 1 through 8].

NEW SECTION. **Section 9. Health care gap analysis -- report.** (1) The department of public health and human services shall conduct an analysis of the gaps in the health care safety net for individuals who are not eligible for the Montana medicaid program. The analysis must examine:

(a) availability of health care services throughout Montana, including but not limited to services provided by hospitals, free clinics, federally qualified community health centers, the Indian health service, and local public health departments;

(b) the amount of uncompensated care and charity care provided to individuals not eligible for the Montana medicaid program;

(c) the amount of taxpayer-subsidized health care provided to individuals through federally qualified community health centers, the Indian health service, local public health departments, and other providers or programs; and

(d) where and how individuals not eligible for the Montana medicaid program obtain health care services, including where they first access the health care system when in need of care.

(2) The department shall limit the analysis to health care services provided to individuals without dependent children who:

(a) are between the ages of 18 and 65;

(b) have a household income below 100% of the federal poverty level; and

(c) do not have health insurance and are not eligible for the Montana medicaid program, are not covered under another health care system that provides benefits for members, and are not eligible for premium assistance for purchase of a qualified health plan as allowed under Public Law 111-148 and Public Law 111-152 and related federal regulations.

(3) In conducting the analysis, the department at a minimum shall determine:

(a) the health care needs of individuals meeting the requirements of subsection (2), the type and location of services currently available to the individuals, the degree to which the individuals used the services, whether areas of the state lack needed primary care services, and whether different services should be available or

services should be located in additional areas of the state;

(b) the percentage of health care services that were provided in an emergency department when care more appropriately could have been provided in a primary care setting; and

(c) the total amount of money spent by geographic region on health care services for individuals not eligible for the Montana medicaid program, including but not limited to uncompensated care, charity care, and taxpayer-subsidized care.

(4) The department shall use data from the most recent time period for which complete data is available.

(5) The department shall report to the governor and, as provided in 5-11-210, to the legislature on the results of the gap analysis no later than November 2016. The children, families, health, and human services interim committee may request information on the status of the study as it progresses.

NEW SECTION. **Section 10. Study of health care facility costs -- reports.** (1) The ~~public service commission provided for in 2-15-2602~~ DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES shall review and analyze health care costs for services provided by hospitals and outpatient centers for surgical services as defined in 50-5-101 to:

(a) determine the cost-shifting strategies used in the pricing of the health care services provided, including but not limited to the percentage of costs paid by governmental, commercial, self-insured, and self-pay payment sources;

(b) evaluate the makeup of the chargemaster used by hospitals for calculating prices for health care services, including but not limited to the rationale for the prices, growth rates in the pricing structure, and how the chargemasters vary by the community or region served by the hospitals;

(c) compare the chargemasters to the actual cost of providing medical services, to the extent the information is available;

(d) review the wage and benefit packages provided to hospital executives, including a comparison of compensation packages offered by for-profit hospitals, nonprofit hospitals, and for-profit divisions of nonprofit hospitals in Montana, Idaho, North Dakota, South Dakota, Utah, and Wyoming;

(e) analyze how compensation packages vary among facilities and how they compare with compensation packages offered to executives of similarly sized nonprofit corporations that operate in Montana; and

(f) evaluate the cost and benefit of rate regulation of hospitals and health care systems as a utility of critical and public resource.

(2) The ~~public service commission~~ DEPARTMENT shall report to:

(a) the children, families, health, and human services interim committee no later than August 2016 on the study results and recommendations; and

(b) the attorney general's office for consideration by the office.

Section 11. Section 33-2-708, MCA, is amended to read:

"33-2-708. Fees and licenses. (1) (a) Except as provided in 33-17-212(2), the commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) biennial renewal of license, $50;

(C) lapsed license reinstatement fee, $100;

(ii) resident insurance producer's license lapsed license reinstatement fee, $100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(iv) insurance adjuster's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(v) insurance consultant's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vi) viatical settlement broker's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vii) resident and nonresident rental car entity producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) quarterly filing fee, $25;

(viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), $50;

(ix) navigator certification:

(A) application for original certification, including issuance of certificate if issued, $100;

(B) biennial renewal of certification, $50;

(C) lapsed certification reinstatement fee, $100;

(x) 50 cents for each page for copies of documents on file in the commissioner's office.

(c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.

(2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization submitting courses or programs for review in any biennium.

(b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).

(3) (a) Except as provided in ~~subsection (3)(b)~~ subsections (3)(b) and (3)(c), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.

(b) The commissioner shall deposit 33% of the money collected under 33-2-705 in the special revenue account provided for in 53-4-1115.

(c) The commissioner shall deposit 38% of the money collected under 33-2-705 in the special revenue account provided for in [section 8].

~~(c)~~(d) All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.

(4) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded."

NEW SECTION. **Section 12. Appropriations.** (1) There is appropriated $35 million in EACH YEAR OF the biennium beginning July 1, 2015, from the special revenue account provided for in [section 8] for the purposes of [sections 1 through 8].

(2) There is appropriated ~~$50,000~~ $200,000 from the general fund to the department of public health and human services for the biennium beginning July 1, 2015, for the health care gap analysis provided for in [section 9]~~.~~

~~(3) There is appropriated $150,000 from the general fund to the public service commission for the biennium beginning July 1, 2015,~~ AND for the health care facility costs study provided for in [section 10].

NEW SECTION. **Section 13. Codification instruction.** [Sections 1 through 8] are intended to be codified as an integral part of Title 53, chapter 3, and the provisions of Title 53, chapter 3, apply to [sections 1 through 8].

NEW SECTION. **Section 14. Effective date.** [This act] is effective July 1, 2015.

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