HOUSE BILL NO. 123

INTRODUCED BY A. CURTIS

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING HEALTH CARE PROVIDER NETWORK DISCLOSURE LAWS; PROVIDING ADDITIONAL INFORMATION AND CONTROL TO HEALTH CARE CONSUMERS; PROVIDING PROCEDURES FOR INFORMING CONSUMERS ABOUT OUT-OF-NETWORK HEALTH CARE COSTS; PROVIDING PROCEDURES FOR INSURERS TO PROVIDE INFORMATION ABOUT OUT-OF-NETWORK HEALTH CARE COSTS; INFORMING PATIENTS ABOUT OPTING OUT OF PROCEDURES; CREATING AN INCENTIVE PROGRAM FOR HEALTH CARE CONSUMERS TO SHOP FOR HEALTH CARE SERVICES; REQUIRING INSURERS TO NOTIFY HEALTH PLAN MEMBERS OF THE AVAILABILITY OF THE SHARED SAVINGS INCENTIVE PROGRAM; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-18-209, 33-35-306, 50-4-504, 50-4-511, 50-4-512, MCA; REPEALING SECTIONS 50-4-516, 50-4-517, AND 50-4-518, MCA; AND PROVIDING ~~A~~ DELAYED EFFECTIVE ~~DATE~~ DATES AND ~~AN~~ APPLICABILITY ~~DATE~~ DATES."

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

(Refer to Third Reading, Blue Bill)

Strike everything after the enacting clause and insert:

NEW SECTION. **Section 1. Short title.** Sections [1 through 4] may be cited as the "Patient's Right to Know of Insurance Coverage Provisions Act".

NEW SECTION. **Section 2. Legislative purpose.** The purpose of [sections 1 through 4] is:

(1) to provide health care consumers with better information on and control over the portion of their health care costs that will be paid by their health insurer and the portion that they will have to pay themselves; and

(2) to introduce elements of competition into the marketplace.

NEW SECTION. **Section 3. Definitions.** As used in [sections 1 through 4], the following definitions

apply:

(1) "Authorized agent" or "agent" means a person or entity:

(a) authorized under federal or state law to receive health care information about a patient; and

(b) to whom the patient has provided a written authorization to obtain information under [sections 1 through 4] on behalf of the patient.

(2) "Billed charge" means the total dollar amount that is charged by a health care provider for health care provided to a patient and that the provider will accept as payment in full, regardless of payer type and regardless of the anticipated amount of net revenue to be received or the anticipated source of payment.

(3) "Health care" includes both physical health care and mental health care.

(4) "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or the practice of a profession.

(5) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, multiple employer welfare arrangement authorized under Title 33, chapter 35, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

NEW SECTION. **Section 4. Disclosures required of health insurers -- limitations.** (1) When requested by an insured or an authorized agent, a health insurer shall provide a summary of the insured's estimated coverage amounts for a specific health care service or course of treatment when an actual billed charge or estimate of billed charges by a health care provider, outpatient center for surgical services, clinic, or hospital exceeds $500.

(2) The request by the insured or the agent for the information required under this section must be made by telephone, in writing, or electronically.

(3) The health insurer shall provide the requested information within 5 business days of the request by the insured or the agent.

(4) If the health insurer has an online consumer cost estimator transparency tool that allows the insured or the authorized agent to estimate the insured's coverage amounts for certain services, including deductible and other cost-sharing amounts, and the insured or the agent chooses to use the transparency tool to obtain estimated coverage amounts, the transparency tool satisfies the requirements of subsection (1).

(5) A health insurer shall make a good faith effort to provide accurate information under this section and is only required to provide information under this section based upon cost estimates and procedure codes obtained by the insured from the insured's health care provider.

(6) A health insurer shall:

(a) advise insureds of their rights under this section in the outline of coverage; and

(b) provide insureds with access to contact information for participating providers who may be available to provide the same medical service.

(7) This section does not apply to emergency medical services provided for the treatment of an emergency medical condition.

NEW SECTION. **Section 5. Short title.** [Sections 5 through 10] may be cited as the "Patient's Right to Shop Act".

NEW SECTION. **Section 6. Definitions.** As used in [sections 5 through 10], the following definitions apply:

(1) "Health care provider" or "provider" means:

(a) an individual who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or the practice of a profession; and

(b) a hospital, critical access hospital, outpatient center for primary care, or outpatient center for surgical services licensed pursuant to Title 50, chapter 5.

(2) (a) "Health insurer" or "insurer" means any disability insurance company, health service corporation, insurer providing disability insurance as described in 33-1-207, captive insurer licensed under Title 33, chapter 28, self-funded multiple welfare arrangement that is not governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq., and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public or private entities.

(b) The term does not include:

(i) group insurance plans established under Title 2, chapter 18, for public employees and officers;

(ii) the Montana university system group benefits plan established in Title 20, chapter 25, part 13;

(iii) publicly funded health care benefit plans offered by public and private entities and the administrators of those plans; or

(iv) health maintenance organizations as defined in Title 33, chapter 31.

(3) "Program" means the shared savings incentive program established by a health insurer pursuant to [section 7].

(4) "Shoppable health care service" means a nonemergency covered health care service as determined by the commissioner and for which a health insurer offers a shared savings incentive under a program that is established pursuant to [section 7] and approved by the commissioner.

NEW SECTION. **Section 7. Shared savings incentive program for shoppable health care services -- filing.** (1) A health insurer shall establish a program that provides incentives for insured individuals who elect to receive shoppable health care services.

(2) Incentives may be calculated:

(a) as a percentage of the savings to the insured and insurer;

(b) as a flat dollar amount; or

(c) by another methodology approved by the commissioner.

(3) The commissioner shall adopt rules specifying the procedures for offering and providing incentives.

(4) The program offered under this section must be filed with and approved by the commissioner.

(5) Shared savings incentive payments made under this section must be considered a medical claim expense for purposes of calculating an insurer's medical loss ratio.

(6) An insurer shall provide notice annually at enrollment or renewal to any individual enrolled in the plan about:

(a) the individual's right to shop for health care services; and

(b) the availability of the incentive program.

NEW SECTION. **Section 8. Website for shoppable health care services.** (1) A health insurer shall establish a secure, interactive website that allows an insured individual to obtain the following information for shoppable health care services:

(a) the payments made by the insurer to the insured's in-network health care providers;

(b) the insured's deductible, copayment, and coinsurance amounts for in-network health care providers;

(c) health care provider quality measures based on quality metric ratings used by the centers for medicare and medicaid services; and

(d) the amount and type of incentive that the insured will receive for choosing a high-quality, lower-cost health care provider.

(2) An insurer may contract for the development and implementation of the interactive website or use a third-party product that meets the requirements of this section.

(3) An insurer shall make the website available for all disability plans offered by the insurer in Montana unless the plan is filed as a health maintenance organization product.

(4) A website developed under this section is considered a form for the purposes of 33-1-501.

NEW SECTION. **Section 9. Program report.** (1) An insurer shall report by March 31 each year on its incentive program information for the previous calendar year.

(2) The commissioner shall submit to the economic affairs interim committee by July 1 each year an aggregate report for all insurers filing the information required under subsection (1).

NEW SECTION. **Section 10. Rulemaking authority.** The commissioner shall adopt rules for carrying out the purposes of [sections 5 through 10], including rules concerning but not limited to:

(1) the acceptable forms of incentive payments and the procedures for offering and providing incentives under [section 7];

(2) the identification and scope of shoppable health care services for the incentive program developed pursuant to [section 7];

(3) the filing and approval process for shoppable health care services; and

(4) the form, manner, and information to be included in the report required under [section 9].

Section 11. Section 33-18-209, MCA, is amended to read:

"33-18-209. Exceptions to discrimination and rebates provision. Nothing in 33-18-206 and 33-18-208 shall be construed as including within the definition of discrimination or rebates any of the following practices:

(1) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the insurer;

(2) in the case of life insurance policies issued on the industrial debit, preauthorized check, bank draft, or similar plans, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer or by preauthorized check, bank draft, or similar plans, in an amount which fairly represents the saving in collection expense;

(3) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(4) reduction of premium rate for policies of large amount but not exceeding savings in issuance and administration expenses reasonably attributable to such policies as compared with policies of similar plan issued in smaller amounts;

(5) issuing life or disability insurance policies on a salary savings or payroll deduction plan at reduced rate reasonably commensurate with the savings made by the use of such plan; and

(6) providing incentive payments pursuant to [section 7]."

Section 12. Section 33-35-306, MCA, is amended to read:

"33-35-306. Application of insurance code to arrangements. (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(c) Title 33, chapter 1, part 7;

(d) 33-3-308;

(e) Title 33, chapter 18, except 33-18-242;

(f) Title 33, chapter 19;

(g) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152, and 33-22-153;

(h) 33-22-512, 33-22-515, 33-22-525, and 33-22-526; ~~and~~

(i) [sections 1 through 4];

(j) [sections 5 through 10]; and

~~(i)~~(k) Title 33, chapter 40, part 1.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked. (Subsection ~~(1)(i)~~ (1)(k) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

Section 13. Section 50-4-504, MCA, is amended to read:

"50-4-504. Definitions. As used in this part, the following definitions apply:

(1) "Authorized agent" or "agent" means a person or entity:

(a) authorized under federal or state law to receive health care information about a patient; and

(b) to whom the patient has provided a written authorization to obtain information under this part on behalf of the patient.

(2) "Billed charge" means the total dollar amount that is charged by a health care provider for health care provided to a patient and that the provider will accept as payment in full, regardless of payer type and regardless of the anticipated amount of net revenue to be received or the anticipated source of payment.

~~(1)~~(3) "Health care" includes both physical health care and mental health care.

~~(2)~~(4) "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

~~(3)~~(5) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, multiple employer welfare arrangement authorized under Title 33, chapter 35, insurer providing disability insurance as described in 33-1-207, and to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities."

Section 14. Section 50-4-511, MCA, is amended to read:

"50-4-511. Legislative purpose. The purpose of 50-4-510 through 50-4-512 is to provide health care consumers with better information on and control over the cost of their medical care and to introduce elements of competition into the marketplace."

Section 15. Section 50-4-512, MCA, is amended to read:

"50-4-512. Disclosures required of health care providers. (1) Upon request of a patient or ~~a patient's~~

an authorized agent, a health care provider, outpatient center for surgical services, clinic, or hospital shall provide the patient or the ~~patient's~~ agent with its estimated billed charge for a health care service or course of treatment that exceeds $500. The estimate must be provided for a service that a patient is receiving or has been recommended to receive~~. The estimate must be provided at the time the service is scheduled or within 10 business days of the patient's or agent's request~~ and must:

(a) indicate network status, if known, under the patient's health plan for a health care service or course of treatment and provide sufficient information regarding the health care service or course of treatment in order to allow the patient to receive a cost estimate from the insurer;

(b) indicate whether the services of other health care providers may be necessary to complete the required medical care and inform the patient that an estimate of those charges and information on network status must be obtained separately from the other health care providers or another health plan; and

(c) advise patients of their rights under [section 4] and this section.

(2) (a) The estimate must be provided at the time the service is provided or within 5 business days of the patient's or agent's request, whichever is sooner.

~~(2)~~(b) The patient or ~~patient's~~ agent may request that the information required under this section be provided in writing or electronically.

(3) The estimated billed charge:

(a) must represent a good faith effort to provide accurate information to the patient or the ~~patient's~~ agent;

(b) is not a binding contract upon the parties; and

(c) is not a guarantee that the estimated amount will be the charged amount or will account for unforeseen conditions.

(4) The health care provider shall offer the patient the opportunity to opt out of receiving services from a nonparticipating health care provider.

(5) This section does not apply to emergency medical services provided for the treatment of an emergency medical condition.

(6) A health care provider who fails to adhere to the requirements of this section is subject to Title 30, chapter 14."

NEW SECTION. **Section 16. Repealer.** The following sections of the Montana Code Annotated are repealed:

50-4-516. Short title.

50-4-517. Legislative purpose.

50-4-518. Disclosures required of health insurers -- limitations.

NEW SECTION. **Section 17. Codification instruction.** [Sections 1 through 10] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 10].

NEW SECTION. **Section 18. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 19. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective January 1, 2018.

(2) [Sections 5 through 10] are effective January 1, 2019.

NEW SECTION. **Section 20. Applicability.** (1) Except as provided in subsection (2), [this act] applies to insurance plans and policies issued or renewed on or after January 1, 2018.

(2) [Sections 5 through 10] apply to insurance plans and policies issued or renewed on or after January 1, 2019.

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