1 SENATE BILL NO. 362

2 INTRODUCED BY E. BUTTREY, J. SESSO, C. SMITH

3

4 A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING TRANSPARENCY IN PRICING OF HEALTH CARE
5 SERVICES; REQUIRING COST DISCLOSURES BY HEALTH CARE PROVIDERS AND HEALTH INSURERS;
6 REQUIRING HEALTH INSURERS TO OFFER TRANSPARENCY TOOLS AND INCENTIVE PROGRAMS FOR
7 HEALTH CARE CONSUMERS; REQUIRING PUBLIC EMPLOYEE GROUP BENEFIT PLANS TO COMPLY
8 WITH TRANSPARENCY REQUIREMENTS; PROVIDING PENALTIES; PROVIDING DEFINITIONS; PROVIDING
9 RULEMAKING AUTHORITY; AMENDING SECTIONS 2-18-702, 2-18-811, 20-25-1303, 33-18-208, 33-18-209,
10 33-22-101, 33-28-207, 33-35-306, 45-5-214, 50-4-504, 50-4-512, AND 50-4-518, MCA; AND PROVIDING
11 EFFECTIVE DATES AND AN APPLICABILITY DATE."

12

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

14

15 NEW SECTION. **Section 1. Transparency in health care services -- legislative intent.** (1) The
16 legislature finds health care consumers often do not have the information needed to make responsible,
17 cost-effective decisions about the health care services they receive.
18 (2) The legislature further finds that consumers are more likely to make good decisions about health care
19 services when they have complete information about the potential costs of care.
20 (3) The legislature further finds that the use of health care payment information, combined with incentives
21 for making cost-effective health care decisions, could stabilize or reduce the costs of health care services.
22 (4) It is the intent of the legislature to:
23 (a) make the costs of health care services and the performance of health care providers more
24 transparent to health care consumers; and
25 (b) create incentives for health care consumers to make cost-effective choices and for providers to make
26 affordable health care services available to consumers.

27

28 NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 6], the following definitions
29 apply:
30 (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 6] on behalf of the patient.

(2) "Covered individual" means an individual who is covered by a health insurer or participates in a group health plan.

(3) "Estimate of total charges" means a comprehensive estimate of the charges for all elements of a health care service that a covered individual may receive.

(4) "Group health plan" or "health plan" means an employee benefit plan that provides medical care and items and services related to medical care to covered individuals, directly or through insurance, reimbursement, or otherwise. The term includes:

(a) any multiple employer welfare arrangement authorized under Title 33, chapter 35; and

(b) to the extent permitted under federal law, any administrator of an insured or self-insured health care benefit plan offered by private entities.

(5) "Health care incentive" or "incentive" means a financial or other incentive that is offered to a covered individual for choosing a lower-cost health care provider who meets quality ratings or measures established by the health insurer or health plan for health care providers who offer the health care service.

(6) "Health care 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 practice of a profession~~ UNDER TITLE 37, CHAPTER 3, TO PRACTICE MEDICINE IN THIS STATE; 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.

(7) "Health care service" means a nonemergency service, procedure, or treatment for which a health insurer or health plan makes coverage available.

(8) "Health insurer" or "insurer" means any health insurance company, health service corporation, captive insurer providing health insurance coverage or group health plans, or insurer providing disability insurance as described in 33-1-207.

(9) "Out-of-pocket expense" means the financial amount a covered individual will be responsible to pay for a health care service.

(10) "Transparency tool" means a secure, interactive mechanism established pursuant to [section 4].

1

2 NEW SECTION. **Section 3. Price transparency for covered individuals.** (1) As a condition of doing
3 business in this state, a health insurer or group health plan shall offer a covered individual or the individual's
4 authorized agent access to a transparency tool that allows the individual to shop for health care service and
5 obtain a comprehensive, good-faith estimate of total charges for the service.

6 (2) The estimate of total charges is not a binding contract upon the parties and is not a guarantee that
7 the estimate will be the charged amount. The estimate must indicate that it does not account for unforeseen
8 charges or all out-of-network charges that may be incurred when the health care service is performed.

9 (3) This section does not apply to health care services for the treatment of an emergency medical
10 condition.

11

12 NEW SECTION. **Section 4. Transparency tool -- proprietary information -- penalty for insurance**
13 **fraud.** (1) A health insurer or group health plan shall make available to covered individuals a secure, interactive
14 mechanism on a website or mobile application that at a minimum:

15 (a) provides a comprehensive, good-faith estimate of total charges for a health care service that shows
16 the covered individual's out-of-pocket costs related to deductibles, copayments, and coinsurance and shows the
17 costs to be paid by the insurer or health plan;

18 (b) provides quality ratings or measures, IF AVAILABLE, for health care providers who offer the health
19 service;

20 (c) identifies whether the covered individual could be eligible for a health care incentive for obtaining the
21 health care service from a specific health care provider; and

22 (d) if possible, provides the amount of or other details related to the incentive.

23 (2) The transparency tool must:

24 (a) provide price information from all health care providers under contract with the insurer; and

25 (b) allow covered individuals to easily obtain, with minimal navigation, the information required under this
26 section.

27 (3) Information obtained through the transparency tool is a trade secret as defined in 30-14-402 and is
28 confidential.

29 (4) An individual who obtains insurance coverage in an effort to use the transparency tool to gain access
30 to the rates an insurer or health plan has negotiated with a health care provider commits the act of insurance

1 fraud as defined in 33-1-1202 and is subject to the penalty provided for in 33-1-1211.
2
3 NEW SECTION. **Section 5. Health care incentive program.** (1) As a condition of doing business in
4 this state, a health insurer or group health plan shall develop and maintain or contract for the development and
5 implementation of a program that provides a health care incentive to covered individuals who choose to receive
6 acceptable quality, lower-cost health care services. The incentive program must be included in all plans offered
7 by the insurer or health plan.
8 (2) The incentive may be provided as:
9 (a) a cash payment;
10 (b) a reduction in the covered individual's deductible or coinsurance amounts; or
11 (c) in another form developed by the insurer in accordance with rules adopted by the commissioner for
12 alternative forms of incentive payments.
13 (3) An insurer or health plan may not offer an incentive to a covered individual for a health care service
14 obtained from a health care provider located:
15 (A) OUT OF STATE; OR
16 (B) more than 20 miles from the covered individual's primary residence if the residence is within 20 miles
17 of a critical access hospital that provides the same health care service.
18 (4) An insurer or health plan shall:
19 (a) before offering the incentive program, file the program with the commissioner for review of
20 compliance with [sections 1 through 6]; and
21 (b) annually provide notice to covered individuals, at enrollment or upon renewal, of the incentive
22 program.
23 (5) Incentive payments made under this section must be considered a medical claim expense for
24 purposes of calculating an insurer's medical loss ratio.
25
26 NEW SECTION. **Section 6. Rulemaking authority.** The commissioner may adopt rules to carry out
27 the purposes of [sections 1 through 6], including but not limited to:
28 (1) the form in which incentives may be provided; and
29 (2) filing and review requirements related to the health care incentive program.
30

1 **Section 7.** Section 2-18-702, MCA, is amended to read:
2 **"2-18-702. Group insurance for public employees and officers.** (1) (a) Except as provided in
3 subsection (1)(c), all counties, cities, towns, school districts, and the board of regents shall upon approval by
4 two-thirds vote of their respective officers and employees enter into group hospitalization, medical, health,
5 including long-term disability, accident, or group life insurance contracts or plans for the benefit of their officers
6 and employees and their dependents. The laws prohibiting discrimination on the basis of marital status in Title
7 49 do not prohibit bona fide group insurance plans from providing greater or additional contributions for insurance
8 benefits to employees with dependents than to employees without dependents or with fewer dependents.
9 (b) The governing body of a county, city, or town may, at its discretion, consider the employees of
10 private, nonprofit economic development organizations, hospitals, health centers, or nursing homes to be
11 employees of the county, city, or town solely for the purpose of participation in group hospitalization, medical,
12 health, including long-term disability, accident, or group life insurance contracts or plans as provided in subsection
13 (1)(a). The governing body of the county, city, or town may require an employee, organization, hospital, health
14 center, or nursing home to pay the actual cost of coverage required for participation or may, at its discretion and
15 subject to any restriction on who may be a member of a group, pay all or part of the cost of coverage of the
16 employee of the organization.
17 (c) The governing body of a county having a taxable valuation of less than $30 million or the board of
18 trustees of a hospital district may, at its discretion, exempt employees of a county hospital, county rest home or
19 nursing home, or hospital district from participation in group hospitalization, medical, health, including long-term
20 disability, accident, or group life insurance contracts or plans provided pursuant to subsection (1)(a) or (1)(b).
21 (2) State employees and elected officials, as defined in 2-18-701, may participate in state employee
22 group benefit plans as are provided for under part 8 of this chapter.
23 (3) For state officers and employees, the premiums required from time to time to maintain the insurance
24 in force must be paid by the insured officers and employees, and the state treasurer shall deduct the premiums
25 from the salary or wages of each officer or employee who elects to become insured, on the officer's or employee's
26 written order, and issue a warrant for the premiums to the insurer.
27 (4) For the purpose of this section, the plans of health service corporations for defraying or assuming
28 the cost of professional services of licensees in the field of health or the services of hospitals, clinics, or
29 sanitariums or both professional and hospital services must be construed as group insurance and the dues
30 payable under the plans must be construed as premiums for group insurance.

1 (5) If the board of trustees of a school district implements a self-insured group health plan or if the board
2 of regents implements an alternative to conventional insurance to provide group benefits to its employees, the
3 board shall maintain the alternative plan on an actuarially sound basis.
4 (6) Contracts or plans offered under this section must meet the requirements of [sections 1 through 6]."
5
6 **Section 8.** Section 2-18-811, MCA, is amended to read:
7 **"2-18-811. General duties of department.** (1) The department shall:
8 ~~(1)~~(a) adopt rules for the conduct of its business under this part and to carry out the purposes of this part;
9 ~~(2)~~(b) negotiate and administer contracts for state employee group benefit plans for a period not to
10 exceed 10 years;
11 ~~(3)~~(c) design state employee group benefit plans, establish specifications for bids, and make
12 recommendations for acceptance or rejection of bids;
13 ~~(4)~~(d) prepare an annual report that describes the state employee group benefit plans being
14 administered, details the historical and projected program costs and the status of reserve funds, and makes
15 recommendations, if any, for change in existing state employee group benefit plans;
16 ~~(5)~~(e) prior to each legislative session, perform or obtain an analysis of rate adequacy of all state
17 employee group benefit plans administered under this part; and
18 ~~(6)~~(f) submit the report required in this section to the office of budget and program planning as a part of
19 the information required by 17-7-111.
20 (2) The department shall comply with the requirements of [sections 1 through 6] for the state employee
21 group benefit plans offered under this part BUT IS NOT REQUIRED TO FILE A PLAN'S INCENTIVE PROGRAM WITH THE
22 COMMISSIONER OF INSURANCE AS REQUIRED UNDER [SECTION 5(4)(A)]."
23
24 **Section 9.** Section 20-25-1303, MCA, is amended to read:
25 **"20-25-1303. Duties of commissioner -- group benefits plans and employee premium levels not**
26 **mandatory subjects for collective bargaining.** (1) The commissioner shall:
27 (a) design group benefits plans and establish premium levels for employees;
28 (b) establish specifications for bids and accept or reject bids for administering group benefits plans;
29 (c) negotiate and administer contracts for group benefits plans;
30 (d) prepare an annual report that:

1 (i) describes the group benefits plans being administered; and
2 (ii) details the historical and projected program costs and the status of reserve funds; and
3 (e) adopt policies for the conduct of business of the advisory committee and to carry out the provisions
4 of this part.
5 (2) The provisions of Title 33 do not apply to the commissioner when exercising the duties provided for
6 in this part.
7 (3) The design or modification of group benefits plans and the establishment of employee premium levels
8 are not mandatory subjects for collective bargaining under Title 39, chapter 31.
9 (4) The commissioner shall comply with the requirements of [sections 1 through 6] for the group benefits
10 plans offered under this part BUT IS NOT REQUIRED TO FILE A PLAN'S INCENTIVE PROGRAM WITH THE COMMISSIONER
11 OF INSURANCE AS REQUIRED UNDER [SECTION 5(4)(A)]."
12
13 **Section 10.** Section 33-18-208, MCA, is amended to read:
14 **"33-18-208. Contract to contain agreements -- rebates prohibited -- life, disability, and annuity**
15 **contracts.** Except as otherwise expressly provided by law, no person shall knowingly:
16 (1) permit or offer to make or make any contract of life insurance, life annuity, or disability insurance or
17 agreement as to such contract other than as plainly expressed in the contract issued thereon;
18 (2) except as provided in [section 5], pay or allow or give or offer to pay, allow, or give, directly or
19 indirectly, as inducement to such insurance or annuity any rebate of premiums payable on the contract or any
20 special favor or advantage in the dividends or other benefits thereon or any paid employment or contract for
21 services of any kind or any valuable consideration or inducement whatever not specified in the contract;
22 (3) directly or indirectly give or sell or purchase or offer or agree to give, sell, purchase, or allow as
23 inducement to such insurance or annuity or in connection therewith and whether or not to be specified in the
24 policy or contract, any agreement of any form or nature promising returns and profits or any stocks, bonds, or
25 other securities or interest present or contingent therein or as measured thereby of any insurance company or
26 other corporation, association, or partnership or any dividends or profits accrued or to accrue thereon; or
27 (4) offer, promise, or give anything of value whatsoever not specified in the contract."
28
29 **Section 11.** Section 33-18-209, MCA, is amended to read:
30 **"33-18-209. Exceptions to discrimination and rebates provision.** Nothing in 33-18-206 and

1 33-18-208 shall be construed as including within the definition of discrimination or rebates any of the following
2 practices:
3 (1) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or
4 otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance,
5 provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for
6 the best interests of the insurer;
7 (2) in the case of life insurance policies issued on the industrial debit, preauthorized check, bank draft,
8 or similar plans, making allowance to policyholders who have continuously for a specified period made premium
9 payments directly to an office of the insurer or by preauthorized check, bank draft, or similar plans, in an amount
10 which fairly represents the saving in collection expense;
11 (3) readjustment of the rate of premium for a group insurance policy based on the loss or expense
12 experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may
13 be made retroactive only for such policy year;
14 (4) reduction of premium rate for policies of large amount but not exceeding savings in issuance and
15 administration expenses reasonably attributable to such policies as compared with policies of similar plan issued
16 in smaller amounts;
17 (5) issuing life or disability insurance policies on a salary savings or payroll deduction plan at reduced
18 rate reasonably commensurate with the savings made by the use of such plan;
19 (6) providing health care incentives pursuant to [section 5]."
20
21 **Section 12.** Section 33-22-101, MCA, is amended to read:
22 **"33-22-101. Exceptions to scope.** (1) Subject to subsection (2), parts 1 through 4 of this chapter,
23 except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136,
24 33-22-138, 33-22-140, 33-22-141, 33-22-142, 33-22-153, 33-22-243, and 33-22-304, and part 19 and [sections
25 1 through 6] of this chapter do not apply to or affect:
26 (a) any policy of liability or workers' compensation insurance with or without supplementary expense
27 coverage;
28 (b) any group or blanket policy;
29 (c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those
30 provisions relating to disability insurance that:

1 (i) provide additional benefits in case of death or dismemberment or loss of sight by accident or
2 accidental means; or
3 (ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit
4 or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or
5 supplemental contract;
6 (d) reinsurance.
7 (2) Sections 33-22-137, 33-22-150 through 33-22-152, and 33-22-301 apply to group or blanket policies."
8
9 **Section 13.** Section 33-28-207, MCA, is amended to read:
10 **"33-28-207. Applicable laws.** (1) The following apply to captive insurance companies:
11 (a) the definitions of commissioner and department provided in 33-1-202, property insurance provided
12 in 33-1-210, casualty insurance provided in 33-1-206, life insurance provided in 33-1-208, health insurance
13 coverage and group health plans provided in 33-22-140, and disability income insurance provided in 33-1-235;
14 (b) the limitation provided in 33-2-705 on the imposition of other taxes;
15 (c) the provisions relating to supervision, rehabilitation, and liquidation of insurance companies as
16 provided for in Title 33, chapter 2, part 13;
17 (d) the provisions of 33-1-311, 33-1-603, 33-3-431, 33-18-201, 33-18-203, 33-18-205, and 33-18-242;
18 (e) the provisions relating to dissolution and liquidation in Title 33, chapter 3, part 6, except that a pure
19 captive insurance company may proceed with voluntary dissolution and liquidation after prior notice to and
20 approval of the commissioner without following the provisions of Title 33, chapter 3, part 6; and
21 (f) the authority of the commissioner under 33-2-701(6) to impose a fine for failure to timely file an annual
22 statement, except that the annual statement requirements in 33-28-107 apply.
23 (2) This chapter may not be construed as exempting a captive insurance company, its parent, or affiliated
24 companies from compliance with the laws governing workers' compensation insurance.
25 (3) A captive insurance company or branch captive insurance company that writes health insurance
26 coverage or group health plans as defined in 33-22-140 shall comply with applicable state and federal laws,
27 including but not limited to [sections 1 through 6].
28 (4) The following provisions apply to captive risk retention groups:
29 (a) those relating to actuarial opinions in Title 33, chapter 1, part 14;
30 (b) those relating to risk-based capital in Title 33, chapter 2, part 19; and

1 (c) those relating to insurance holding company systems in Title 33, chapter 2, part 11.
2 (5) Except as expressly provided in this chapter, the provisions of Title 33 do not apply to captive
3 insurance companies."
4
5 **Section 14.** Section 33-35-306, MCA, is amended to read:
6 **"33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter,
7 self-funded multiple employer welfare arrangements are subject to the following provisions:
8 (a) 33-1-111;
9 (b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare
10 arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;
11 (c) Title 33, chapter 1, part 7;
12 (d) 33-3-308;
13 (e) Title 33, chapter 18, except 33-18-242;
14 (f) Title 33, chapter 19;
15 (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,
16 33-22-152, and 33-22-153;
17 (h) 33-22-512, 33-22-515, 33-22-525, and 33-22-526; ~~and~~
18 (i) [sections 1 through 6]; and
19 ~~(i)~~(j) Title 33, chapter 40, part 1.
20 (2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple
21 employer welfare arrangement that has been issued a certificate of authority that has not been revoked.
22 (Subsection ~~(1)(i)~~ (1)(j) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"
23
24 **Section 15.** Section 45-5-214, MCA, is amended to read:
25 **"45-5-214. Assault with bodily fluid.** (1) A person commits the offense of assault with a bodily fluid if
26 the person purposely causes one of the person's bodily fluids to make physical contact with:
27 (a) a law enforcement officer, a staff person of a correctional or detention facility, or a health care
28 provider, as defined in 50-4-504(4)(a), including a health care provider performing emergency services, while the
29 health care provider is acting in the course and scope of the health care provider's profession and occupation:
30 (i) during or after an arrest for a criminal offense;

1 (ii) while the person is incarcerated in or being transported to or from a state prison, a county, city, or
2 regional jail or detention facility, or a health care facility; or
3 (iii) if the person is a minor, while the youth is detained in or being transported to or from a county, city,
4 or regional jail or detention facility or a youth detention facility, secure detention facility, regional detention facility,
5 short-term detention center, state youth correctional facility, health care facility, or shelter care facility; or
6 (b) an emergency responder.
7 (2) A person convicted of the offense of assault with a bodily fluid shall be fined an amount not to exceed
8 $1,000 or incarcerated in a county jail or a state prison for a term not to exceed 1 year, or both.
9 (3) The youth court has jurisdiction of any violation of this section by a minor, unless the charge is filed
10 in district court, in which case the district court has jurisdiction.
11 (4) As used in this section, the following definitions apply:
12 (a) "Bodily fluid" means any bodily secretion, including but not limited to feces, urine, blood, and saliva.
13 (b) "Emergency responder" means a licensed medical services provider, law enforcement officer,
14 firefighter, volunteer firefighter or officer of a nonprofit volunteer fire company, emergency medical technician,
15 emergency nurse, ambulance operator, provider of civil defense services, or any other person who in good faith
16 renders emergency care or assistance at a crime scene or the scene of an emergency or accident."
17
18 **Section 16.** Section 50-4-504, MCA, is amended to read:
19 **"50-4-504. Definitions.** As used in this part, the following definitions apply:
20 <u>(1) "Authorized agent" or "agent" means a person or entity:</u>
21 <u>(a) authorized under federal or state law to receive health care information about a patient; and</u>
22 <u>(b) to whom the patient has provided a written authorization to obtain information under this part on</u>
23 <u>behalf of the patient.</u>
24 <u>(2) "Estimate of total charges" means:</u>
25 <u>(A) a comprehensive estimate of the charges for all elements of a health care service IF THE SERVICE IS</u>
26 <u>BEING PROVIDED BY:</u>
27 <u>(I) A PHYSICIAN;</u>
28 <u>(II) ANY OTHER TYPE OF HEALTH CARE PROVIDER AS DEFINED IN SUBSECTION (4)(A) WHO IS EMPLOYED BY A</u>
29 <u>FACILITY LISTED IN SUBSECTION (4)(B); OR</u>
30 <u>(III) A HEALTH CARE PROVIDER AS DEFINED IN SUBSECTION (4)(B); OR</u>

1 (B) THE CHARGE FOR AN INDIVIDUAL HEALTH CARE PROVIDER'S HEALTH CARE SERVICE IF THE PROVIDER MEETS
2 THE DEFINITION OF SUBSECTION (4)(A) AND IS NOT EMPLOYED BY A FACILITY LISTED IN SUBSECTION (4)(B).
3 (1)(3) "Health care" includes both physical health care and mental health care.
4 (2)(4) "Health care provider" or "provider" means:
5 (a) a person an individual who is licensed, certified, or otherwise authorized by the laws of this state to
6 provide health care in the ordinary course of business or practice of a profession; and
7 (b) a hospital, critical access hospital, outpatient center for primary care, or outpatient center for surgical
8 services licensed pursuant to Title 50, chapter 5.
9 (5) "Health care service" means a nonemergency service, procedure, or treatment offered by a health
10 care provider.
11 (3)(6) "Health insurer" means any health insurance company, health service corporation, health
12 maintenance organization, insurer providing disability insurance as described in 33-1-207, and to the extent
13 permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit
14 plan offered by public and private entities."
15
16 **Section 17.** Section 50-4-512, MCA, is amended to read:
17 **"50-4-512. Disclosures required of health care providers.** (1) Upon written request of a patient or a
18 patient's an authorized agent, a health care provider, outpatient center for surgical services, clinic, or hospital
19 shall provide the patient or the patient's agent with its estimated charge a comprehensive, good-faith estimate
20 of total charges for a health care service or course of treatment that exceeds $500 $250. The estimate must be
21 provided for a health care service that a patient is receiving or has been recommended to receive. The estimate
22 must be provided at the time the service is scheduled or within 10 5 business days of the patient's or agent's
23 request receipt of the written request and of any additional information needed to provide a comprehensive
24 estimate of total charges.
25 (2) The estimate of total charges must:
26 (a) indicate network status, if known, under an insured patient's health plan and, if unknown, provide the
27 patient with contact information for the patient's health insurer; AND
28 (b) IF KNOWN, indicate whether the services of other health care providers may be necessary to complete
29 the required medical care HEALTH CARE SERVICE OR COURSE OF TREATMENT BEING PROVIDED OR RECOMMENDED BY
30 THE HEALTH CARE PROVIDER and inform the patient that an estimate of those charges and information on network

1 status must be obtained separately from the other health care providers or another health plan; and
2 (c) advise patients of their rights under 50-4-518.
3 (3) If the patient is uninsured, the health care provider shall:
4 (a) include in the total cost estimate any financial assistance available to the patient FROM THE HEALTH
5 CARE PROVIDER; and
6 (b) direct the patient or the agent to websites, IF AVAILABLE, that provide information about standard
7 charges for the type of health care provider involved in the health care service.
8 (2)(4) The patient or patient's agent may request that the information required under this section be
9 provided in writing or electronically.
10 (3)(5) The estimated charge estimate of total charges:
11 (a) must represent a good faith effort to provide accurate information to the patient or the patient's agent;
12 (b) is not a binding contract upon the parties; and
13 (c) is not a guarantee that the estimated amount will be the charged amount or will account for
14 unforeseen conditions.
15 (6) This section does not apply to health care services provided for the treatment of an emergency
16 medical condition.
17 (7) (a) A patient who believes a health care provider has failed to adhere to the requirements of this
18 section may file a written complaint with the department of public health and human services.
19 (b) If the department of public health and human services determines that a violation of this section has
20 occurred, the department may fine the provider up to 5% of the disputed amount, not to exceed $500 per
21 occurrence. Fines collected pursuant to this section must be deposited in the general fund."
22
23 **Section 18.** Section 50-4-518, MCA, is amended to read:
24 **"50-4-518. Disclosures required of health insurers -- limitations.** (1) When requested by an insured
25 or the insured's an authorized agent, a health insurer shall provide a summary of the insured's coverage for a
26 specific health care service or course of treatment when an actual charge or an estimate of total charges by a
27 health care provider, outpatient center for surgical services, clinic, or hospital exceeds $500 $250.
28 (2) The request by the insured or insured's the authorized agent may request that for the information
29 required under this section must be provided made by phone, in writing, or electronically.
30 (3) If the insurer has an online consumer cost estimator transparency tool that allows the insured or the

1 authorized agent to estimate the insured's coverage amounts for certain services, including deductible and other
2 cost-sharing amounts, and the insured or the agent chooses to use the transparency tool to obtain estimated
3 coverage amounts, the transparency tool satisfies the requirements of subsection (1).
4 ~~(3)~~(4) The health insurer shall make a good faith effort to provide accurate information under this section.
5 The health insurer is only required to provide information under this section based upon cost estimates and
6 procedure codes obtained by the insured from the insured's health care provider."
7
8 NEW SECTION. **Section 19. Codification instruction.** [Sections 1 through 6] are intended to be
9 codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections
10 1 through 6].
11
12 NEW SECTION. **Section 20. Effective date -- applicability date.** (1) Except as provided in subsections
13 (2) and (3), [this act] is effective January 1, 2019.
14 (2) [Sections 15 through 18] and this section are effective October 1, 2017.
15 (3) [Sections 10 and 11] are effective January 1, 2018.
16 (4) [Section 5] applies to health plans offered on or after January 1, 2019.
17 - END -