SENATE BILL NO. 96

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A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING THE MONTANA RIGHT TO SHOP ACT; CREATING AN INCENTIVE PROGRAM FOR HEALTH CARE CONSUMERS TO SHOP FOR HEALTH CARE SERVICES; REQUIRING INSURERS TO ALLOW FOR COMPARISON SHOPPING BY CONSUMERS; REQUIRING HEALTH CARE PROVIDERS AND HEALTH INSURERS TO PROVIDE INFORMATION ON COSTS BEFORE TREATMENT IS PROVIDED; PROVIDING PENALTIES FOR HEALTH CARE PROVIDERS WHO FAIL TO PROVIDE INFORMATION; REQUIRING INSURERS TO NOTIFY HEALTH PLAN MEMBERS OF THE AVAILABILITY OF THE SHARED SAVINGS INCENTIVE PROGRAM; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-18-201, 33-18-209, 33-18-242, 45-5-214, 50-4-504, 50-4-512, 50-4-516, 50-4-517, AND 50-4-518, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

SECTION 1. SECTION 33-18-201, MCA, IS AMENDED TO READ:

"33-18-201. Unfair claim settlement practices prohibited. A person may not, with such frequency as to indicate a general business practice, do any of the following:

(1) misrepresent pertinent facts or insurance policy provisions relating to coverages at issue;

(2) fail to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims arising under

insurance policies;

(4) refuse to pay claims without conducting a reasonable investigation based upon all available information;

(5) fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) neglect to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(7) compel insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempt to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempt to settle claims on the basis of an application that was altered without notice to or knowledge or consent of the insured;

(10) make claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made;

(11) make known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) delay the investigation or payment of claims by requiring an insured, claimant, or physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) fail to promptly settle claims, if liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; ~~or~~

(14) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

(15) fail to comply with the requirements of [section 9]."

SECTION 2. 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;

(6) providing incentive payments pursuant to [section 10]."

SECTION 3. SECTION 33-18-242, MCA, IS AMENDED TO READ:

"33-18-242. Independent cause of action -- burden of proof. (1) An insured or a third-party claimant has an independent cause of action against an insurer for actual damages caused by the insurer's violation of subsection (1), (4), (5), (6), (9), ~~or~~ (13), or (15) of 33-18-201.

(2) In an action under this section, a plaintiff is not required to prove that the violations were of such frequency as to indicate a general business practice.

(3) An insured who has suffered damages as a result of the handling of an insurance claim may bring an action against the insurer for breach of the insurance contract, for fraud, or pursuant to this section, but not under any other theory or cause of action. An insured may not bring an action for bad faith in connection with the

handling of an insurance claim.

(4) In an action under this section, the court or jury may award such damages as were proximately caused by the violation of subsection (1), (4), (5), (6), (9), ~~or~~ (13), or (15) of 33-18-201. Exemplary damages may also be assessed in accordance with 27-1-221.

(5) An insurer may not be held liable under this section if the insurer had a reasonable basis in law or in fact for contesting the claim or the amount of the claim, whichever is in issue.

(6) (a) An insured may file an action under this section, together with any other cause of action the insured has against the insurer. Actions may be bifurcated for trial where justice so requires.

(b) A third-party claimant may not file an action under this section until after the underlying claim has been settled or a judgment entered in favor of the claimant on the underlying claim.

(7) The period prescribed for commencement of an action under this section is:

(a) for an insured, within 2 years from the date of the violation of 33-18-201; and

(b) for a third-party claimant, within 1 year from the date of the settlement of or the entry of judgment on the underlying claim.

(8) As used in this section, an insurer includes a person, firm, or corporation utilizing self-insurance to pay claims made against them."

Section 4. Section 45-5-214, MCA, is amended to read:

"45-5-214. Assault with bodily fluid. (1) A person commits the offense of assault with a bodily fluid if the person purposely causes one of the person's bodily fluids to make physical contact with:

(a) a law enforcement officer, a staff person of a correctional or detention facility, or a health care provider, as defined in 50-4-504(4)(a), including a health care provider performing emergency services, while the health care provider is acting in the course and scope of the health care provider's profession and occupation:

(i) during or after an arrest for a criminal offense;

(ii) while the person is incarcerated in or being transported to or from a state prison, a county, city, or regional jail or detention facility, or a health care facility; or

(iii) if the person is a minor, while the youth is detained in or being transported to or from a county, city, or regional jail or detention facility or a youth detention facility, secure detention facility, regional detention facility, short-term detention center, state youth correctional facility, health care facility, or shelter care facility; or

(b) an emergency responder.

(2) A person convicted of the offense of assault with a bodily fluid shall be fined an amount not to exceed $1,000 or incarcerated in a county jail or a state prison for a term not to exceed 1 year, or both.

(3) The youth court has jurisdiction of any violation of this section by a minor, unless the charge is filed in district court, in which case the district court has jurisdiction.

(4) As used in this section, the following definitions apply:

(a) "Bodily fluid" means any bodily secretion, including but not limited to feces, urine, blood, and saliva.

(b) "Emergency responder" means a licensed medical services provider, law enforcement officer, firefighter, volunteer firefighter or officer of a nonprofit volunteer fire company, emergency medical technician, emergency nurse, ambulance operator, provider of civil defense services, or any other person who in good faith renders emergency care or assistance at a crime scene or the scene of an emergency or accident."

Section 5. Section 50-4-504, MCA, is amended to read:

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

(1) "Allowed amount" means:

(a) the contractually agreed-upon amount paid by a health insurer to a health care provider participating in the insurer's network; or

(b) the amount the health plan is required to pay for out-of-network covered benefits provided to the insured individual.

(2) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

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

~~(2)~~(4) "Health care provider" or "provider" means:

(a) ~~a person~~ 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; 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.

~~(3)~~(5) (A) "Health insurer" or "insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, ~~entity offering coverage that is subject to the requirements of Public Law 111-148 and Public Law 111-152,~~ 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.

(B) THE TERM INCLUDES THE STATE EMPLOYEE GROUP INSURANCE PROGRAM ESTABLISHED IN TITLE 2, CHAPTER 18, PART 8, AND THE MONTANA UNIVERSITY SYSTEM GROUP BENEFIT PLANS ESTABLISHED IN TITLE 20, CHAPTER 25, PART 13.

(6) "Program" means the shared savings incentive program established by a health insurer pursuant to [section ~~7~~ 10].

(7) (a) "Shoppable health care service" means a health care service for which a health insurer offers a shared savings incentive payment under the program established pursuant to [section ~~7~~ 10]. At a minimum, the term includes:

(i) physical and occupational therapy services;

(ii) obstetrical and gynecological services;

(iii) radiology and imaging services;

(iv) laboratory services;

(v) infusion therapy;

(vi) inpatient and outpatient surgical procedures; and

(vii) outpatient nonsurgical diagnostic tests or procedures.

(b) The term may include additional services ~~as provided~~ THAT ARE NOT PROHIBITED by rule by the commissioner."

Section 6. Section 50-4-512, MCA, is amended to read:

"50-4-512. Disclosures required of health care providers -- failure to disclose a deceptive trade practice. (1) ~~Upon~~ Before a nonemergency admission, procedure, or service and upon request of a patient, a prospective patient, or a patient's agent, a health care provider~~, outpatient center for surgical services, clinic, or hospital~~ shall within 2 working days provide the patient, the prospective patient, or the patient's agent with ~~its~~:

(a) the estimated charge for a health care service or course of treatment ~~that exceeds $500~~, including any ~~facility~~ fees; and

(b) if the patient or prospective patient has coverage through a health insurer, the allowed amount for the admission, procedure, or service and any related ~~facility~~ fees. ~~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.~~

(2) If a health care provider is unable to provide a specific amount in advance as required under

subsection (1) because the provider is unable to predict the specific treatment or diagnostic code, the provider shall disclose all the information that is available for the estimated amount, including the amount of any required ~~facility~~ fees. A provider shall disclose the incomplete nature of the estimate and shall provide the patient, prospective patient, or patient's agent with an updated estimate when additional information is known.

(3) (a) If the patient or prospective patient has coverage through a health insurer, a health care provider that participates in a health insurer's network shall, upon request of the patient, prospective patient, or patient's agent, provide sufficient information regarding the proposed nonemergency admission, procedure, or service for the person to receive a cost estimate from the insurer to identify the allowed amount and any out-of-pocket costs. The estimate may be based on the information available to the provider at the time of the request.

(b) The insurer may make the cost estimate available through a toll-free telephone number or a website or third-party product that meets the requirements of [section ~~8~~ 11]. A health care provider may assist a patient, prospective patient, or patient's agent in using an insurer's toll-free number, website, or third-party product.

~~(2)~~(4) The patient or patient's agent may request that the information required under this section be provided in writing or electronically.

~~(3)~~(5) The estimated 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.

(6) (a) Failure by a health care provider to adhere to the requirements of this section is an unfair or deceptive practice for the purposes of Title 30, chapter 14, part 1.

(b) A patient who believes a health care provider has failed to adhere to the requirements of this section may file a complaint with the department of justice pursuant to Title 30, chapter 14, part 1.

(c) (i) After a patient files a complaint and while the patient is waiting for a response to the complaint from the health care provider, the health care provider may not attempt to collect the disputed amount, ask a third-party entity to collect the disputed amount, or take any other action that may impair the credit history or credit rating of the patient.

(ii) If the health care provider has already involved a third-party entity to collect the amount billed, the health care provider shall immediately notify the third-party entity of the complaint. The third-party entity shall cease collection activities while the complaint is pending.

(d) (i) If the health care provider's response fails to resolve the complaint to the patient's satisfaction, the health care provider or the consumer may file an action in district court.

(ii) If the court rules in the patient's favor, the patient is responsible for the lesser of:

(A) the amount billed for the admission, procedure, or service; or

(B) 130% of the medicare reimbursement rate for the admission, procedure, or service.

(iii) If the court rules in favor of the health care provider, the patient is responsible for the amount originally billed by the provider for the admission, procedure, or service.

(e) Upon resolution of the complaint informally with the health care provider or through a final decision of a district judge, the health care provider:

(i) may resume collection activities if the complaint is resolved in favor of the health care provider, including continuation of the use of a third-party entity to collect the amount; or

(ii) if the complaint is resolved in favor of the patient, shall bill the amount determined pursuant to subsection (6)(d)(ii) as if IT were a new bill. If the bill remains unpaid, the provider shall follow the provider's usual collection procedures and schedules to collect any overdue amount."

Section 7. Section 50-4-516, MCA, is amended to read:

"50-4-516. Short title. Sections 50-4-516 through 50-4-518 and [sections ~~7 through 10~~ 10 THROUGH 13] may be cited as the ~~"Patient's Right to Know of Insurance Coverage Provisions Act"~~ "Montana Right to Shop Act"."

Section 8. Section 50-4-517, MCA, is amended to read:

"50-4-517. Legislative purpose. The purpose of 50-4-516 through 50-4-518 and [sections ~~7 through 10~~ 10 THROUGH 13] is:

(1) to provide health care consumers with better information regarding 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."

Section 9. Section 50-4-518, MCA, is amended to read:

"50-4-518. Disclosures required of health insurers -- limitations. (1) ~~When requested~~ Within 2 working days of a request by an insured or the insured's agent, a health insurer shall provide a ~~summary of the~~

~~insured's coverage for a specific health care service or course of treatment when an actual charge or estimate of charges by a health care provider, outpatient center for surgical services, clinic, or hospital exceeds $500~~ good faith estimate of the allowed amount and any amount the insured will be responsible to pay out of pocket for a proposed nonemergency procedure or service that is a medically necessary covered benefit from a health care provider in the insurer's network. The estimate must include any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the insurer at the time the request is made.

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

(3) The health insurer shall make a good faith effort to provide accurate information under this section. ~~The health insurer 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~~ The insurer shall notify the insured or the insured's agent that the costs are estimates and the actual amount of out-of-pocket costs may vary due to unforeseen services that arise out of the proposed nonemergency procedure or service.

(4) Nothing in this section prohibits an insurer from imposing cost-sharing requirements disclosed in the insured's health plan or certificate of insurance for unforeseen health care services that arise out of the nonemergency procedure or service or for a procedure or service provided to the insured that was not in the original estimate.

(5) FAILURE BY A HEALTH INSURER TO ADHERE TO THE REQUIREMENTS OF THIS SECTION IS AN UNFAIR TRADE PRACTICE FOR THE PURPOSES OF TITLE 33, CHAPTER 18."

NEW SECTION. **Section 10. Shared savings incentive program for shoppable health care services -- filing with commissioner.** (1) A health insurer shall develop and implement or contract for the development and implementation of a program that provides incentives for insured individuals who elect to receive shoppable health care services that are covered by the plan from providers that charge less than the average price paid by the insurer for the shoppable health care service.

(2) (a) Incentives may be calculated as a percentage of the difference in price, as a flat dollar amount, or by another reasonable methodology approved by the commissioner.

(b) The insurer shall provide the incentive as a cash payment OR OTHER ACCEPTABLE FORM OF PAYMENT to the insured.

(3) The program shall provide insured individuals with at least 50% of the insurer's saved costs for each service or category of shoppable health care service resulting from shopping by the insured when the savings exceeds $50.

(4) An insurer shall base the average price used for calculating the incentive payment on:

(a) the average amount paid to an in-network provider for the procedure or service under the insured's health plan in the last calendar year; or

(b) an alternate methodology approved by the commissioner.

(5) If an insured individual receives a shoppable health care service from an out-of-network provider that results in a shared savings incentive payment, the individual's insurer shall apply the amount the individual paid for the shoppable health care service toward the cost-sharing requirement specified in the individual's health plan as if the health care services were provided by an in-network provider.

(6) (a) Before offering the incentive program to any insured individual, a health insurer shall file a description of the program with the commissioner in a manner established by the commissioner.

(b) The commissioner ~~may~~ SHALL review the filing to determine if the program complies with the requirements of this section. Filings and any supporting documentation made pursuant to this subsection (6) are confidential until the filing has been reviewed and approved. IF THE COMMISSIONER TAKES NO ACTION ON THE FILING WITHIN 60 DAYS OF RECEIPT OF THE FILING, THE FILING IS CONSIDERED TO BE APPROVED.

(7) Shared savings incentive payments made under this section are not an administrative expense of the insurer for rate development or rate filing purposes.

NEW SECTION. **Section 11. Website for shoppable health care services.** (1) (a) A health insurer shall establish a secure, interactive mechanism on a publicly accessible website that allows an insured individual to request and obtain information on the payments made by the insurer to that individual's in-network providers for shoppable health care services. The mechanism must allow the individual to compare the amount the insurer pays to in-network providers for the service with the average price for the service as calculated in accordance with [section ~~7~~ 10].

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

(2) Information obtained through the interactive mechanism is not considered a trade secret as defined in 30-14-402 and is not subject to confidentiality provisions related to trade secrets in Title 33.

NEW SECTION. **Section 12. Program report.** (1) An insurer shall report by March 31 each year on the following information for the previous calendar year:

(a) the total number of shared savings incentive payments made pursuant to [section ~~7~~ 10];

(b) the total payments;

(c) the use of shoppable health care services by category of service;

(d) the average amount of incentive payment made by category of service;

(e) the total savings achieved for shoppable health care services that resulted in shared savings payments made pursuant to the program guidelines, broken down by category of service; and

(f) the total number and percentage of an insurer's enrollees that participated in such transactions.

(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 13. Rulemaking authority.** The commissioner shall adopt rules related to the:

(1) calculation of the shared incentive payment;

(2) calculation of the average price used for determining incentive payments;

(3) ACCEPTABLE FORMS OF INCENTIVE PAYMENTS;

~~(3)~~(4) procedures for filing and review of the program description; ~~and~~

~~(4)~~(5) form and manner for reporting the information required under ~~[section 9]~~ [SECTION 12]; AND

(6) CONTENT AND FUNCTIONALITY OF WEBSITES, INTERACTIVE MECHANISMS, OR THIRD-PARTY PRODUCTS FOR SHOPPABLE HEALTH CARE SERVICES ESTABLISHED PURSUANT TO [SECTION 11].

NEW SECTION. **Section 14. Availability of shared incentive payment program -- notice required of health insurers.** A health insurer subject to the provisions of Title 50, chapter 4, part 5, shall:

(1) make the shared incentive payment program provided for in [section ~~7~~ 10] available as a component of all health plans offered by the insurer in this state; and

(2) provide notice annually at enrollment or renewal about the availability of the program to any individual who is enrolled in a health plan eligible for the program.

NEW SECTION. **Section 15. Codification instruction.** (1) [Sections ~~7 through 10~~ 10 THROUGH 13] are intended to be codified as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [sections ~~7 through 10~~ 10 THROUGH 13].

(2) [Section ~~11~~ 14] is intended to be codified as an integral part of Title 33, chapter 1, part 1, and the provisions of Title 33, chapter 1, part 1, apply to [section ~~11~~ 14].

NEW SECTION. **Section 16. Effective date.** [This act] is effective January 1, 2018.

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