HOUSE BILL NO. 620

INTRODUCED BY J. HAMILTON

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING HEALTH CARE PROVIDERS AND INSURERS TO PROVIDE CERTAIN BILLING AND PAYMENT INFORMATION TO PATIENTS; ALLOWING PATIENTS TO DELAY PAYMENT WHEN INFORMATION IS NOT PROVIDED; PROHIBITING COLLECTION OF DELAYED PATIENT PAYMENTS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-22-101, 33-31-111, AND 33-35-306, MCA; AND PROVIDING EFFECTIVE DATES."

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

NEW SECTION. **Section 1. Health practitioner billing requirements.** (1) A person who is licensed under Title 37 to provide health care services in the ordinary course of business or practice of a profession and who is not employed by a health care facility, as defined in 50-5-101, shall provide patients with:

(a) a list of all charges billed by the provider that includes a detailed explanation, in plain language, of the item, service, procedure, or treatment for which the charge was made;

(b) a copy of all billing documents submitted to the health insurance issuer, as defined in 33-22-140, multiple employer welfare arrangement subject to Title 33, chapter 35, government assistance program, or other third-party payor responsible for all or a portion of the cost of the item, service, procedure, or treatment a patient received; and

(c) if the provider is referring a patient to another health care provider or a health care facility, as defined in 50-5-101, a description of:

(i) any professional relationship the provider has with the health care provider or facility to which the patient is being referred; and

(ii) any potential conflict of interest that exists with use of the health care provider or facility to which the patient is being referred.

(2) A patient is not responsible for paying the patient's share of the costs of the health care item, service, procedure, or treatment until the health care provider has provided the information required under this section. When a patient has delayed payment pending receipt of the information, a health care provider may not:

(a) transfer or sell to a third party the right to collect the billed charges that have not been paid;

(b) furnish adverse information to a consumer reporting agency regarding the payment owed by the patient;

(c) take any other action that may impair the credit rating of the patient; or

(d) attempt to collect from the patient through litigation or another means the billed charges that have not been paid because the required information has not been provided.

NEW SECTION. **Section 2. Health care facility billing requirements.** (1) A health care facility other than an intermediate care facility for the developmentally disabled shall provide patients with:

(a) a list of all charges billed by the facility or by a health care provider employed by the facility that includes a detailed explanation, in plain language, of the item, service, procedure, or treatment for which the charge was made;

(b) a copy of all billing documents submitted to the health insurance issuer, as defined in 33-22-140, multiple employer welfare arrangement subject to Title 33, chapter 35, government assistance program, or other third-party payor responsible for paying all or a portion of the item, service, procedure, or treatment a patient received; and

(c) if the facility is referring a patient to another health care facility or a health care provider licensed under Title 37, a description of:

(i) any professional relationship the facility has with the health care provider or facility to which the facility is referring the patient; and

(ii) any potential conflict of interest that exists with use of the health care provider or facility to which the patient is being referred.

(2) A health care facility that cares for or treats a patient on a long-term basis shall provide the information required under subsection (1) on an annual basis for any item, service, procedure, or treatment that is billed on a regular basis while the patient is in or being treated by the facility.

(3) A patient is not responsible for paying the patient's share of the costs of the health care services until the health care facility has provided the information required under this section. When a patient has delayed payment pending receipt of the information, a health care facility may not:

(a) transfer or sell to a third party the right to collect the billed charges that have not been paid;

(b) furnish adverse information to a consumer reporting agency regarding the payment owed by the patient;

(c) take any other action that may impair the credit rating of the patient; or

(d) attempt to collect from the patient through litigation or another means the billed charges that have not been paid because the required information has not been provided.

NEW SECTION. **Section 3. Payment of claims -- required information -- rulemaking.** (1) Using the form approved by the commissioner, a health insurance issuer, multiple employer welfare arrangement, or third-party administrator that provides health insurance coverage under this chapter shall provide an insured with the following information related to a claim submitted for payment:

(a) a list of each billed charge and the amount of the charge that was paid by the issuer, multiple employer welfare arrangement, or third-party administrator; and

(b) a plain-language description of the reason payment was made, partially made, or not made for each charge.

(2) The information required under subsection (1) must be included next to each billed charge in easily readable type.

(3) The commissioner shall adopt rules specifying the form of the notice required under this section.

Section 4. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. (1) Subject to subsection (2), parts 1 through 4 of this chapter, 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, 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 of this chapter do not apply to or affect:

(a) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(b) any group or blanket policy;

(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or

supplemental contract;

(d) reinsurance.

(2) Sections 33-22-137, [section 3], 33-22-150 through 33-22-152, and 33-22-301 apply to group or blanket policies."

Section 5. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under Title 33, chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, parts 7 and 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Title 33, chapter 1, parts 12 and 13, 33-2-1114, 33-2-1211, 33-2-1212, Title 33, chapter 2, parts 13,

19, and 23, 33-3-401, 33-3-422, 33-3-431, Title 33, chapter 3, part 6, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, [section 3], 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152, 33-22-153, 33-22-156 through 33-22-159, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and Title 33, chapter 32, apply to health maintenance organizations."

Section 6. 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) Title 33, chapter 2, part 23;

(e) 33-3-308;

(f) Title 33, chapter 7;

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

(h) Title 33, chapter 19;

(i) 33-22-107, [section 3], 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; and

(j) 33-22-512, 33-22-515, 33-22-525, and 33-22-526.

(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."

NEW SECTION. **Section 7. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 37, chapter 2, part 3, and the provisions of Title 37, chapter 2, part 3, apply to [section 1].

(2) [Section 2] is intended to be codified as an integral part of Title 50, chapter 5, part 1, and the provisions of Title 50, chapter 5, part 1, apply to [section 2].

(3) [Section 3] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 3].

NEW SECTION. **Section 8. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective October 1, 2019.

(2) [Section 3] is effective January 1, 2020.

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