



AN ACT AUTHORIZING DIRECT PATIENT CARE AGREEMENTS; ESTABLISHING REQUIREMENTS FOR DIRECT PATIENT CARE AGREEMENTS; ESTABLISHING THAT DIRECT PATIENT CARE AGREEMENTS ARE NOT HEALTH INSURANCE; MAKING DIRECT PATIENT CARE AGREEMENTS SUBJECT TO CONSUMER PROTECTION LAWS; AND AMENDING SECTIONS 30-14-102, 33-1-102, 33-1-201, 33-1-207, 33-22-140, 33-30-101, 33-31-102, AND 50-4-105, MCA.

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

Section 1. Definitions. As used in [sections 1 through 4], the following definitions apply:

(1) "Direct fee" means a fee charged by a health care provider to a patient or a patient's designee for health care services provided by, or to be provided by, the health care provider to the patient. The term includes a fee in any form, including but not limited to a:

- (a) monthly retainer;
- (b) membership fee;
- (c) subscription fee;
- (d) fee paid under a direct patient service agreement; or
- (e) fee for a service, visit, or episode of care.

(2) "Direct patient care" means a health care service provided by a health care provider to a patient in return for payment in accordance with a direct fee. The term includes services provided by means of telemedicine as defined in 33-22-138.

(3) "Health care 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.

(4) "Health care services" means any care, service, or procedure provided by a health care provider, including medical or psychological diagnosis, treatment, evaluation, advice, or other services that affect the

structure or any function of the human body.

Section 2. Direct patient care agreements -- requirements -- prohibition. (1) A patient or the patient's legal representative may enter into a direct patient care agreement with a health care provider to arrange for health care services for the patient.

(2) A direct patient care agreement must be in writing, and the patient or the patient's legal representative must be given a copy of the written agreement at the time the agreement is signed.

(3) The agreement must:

(a) describe the health care services to be provided in exchange for payment of a direct fee;

(b) specify the direct fee required and any additional fees to be paid by a third party;

(c) specify the patient's payment obligation;

(d) prohibit the provider from charging or receiving additional compensation for health care services included in the direct fee;

(e) prohibit the provider from submitting to a health insurance issuer or a contractor or subcontractor of a health insurance issuer a claim for payment for health care services provided to a patient under a direct patient care agreement;

(f) meet the disclosure requirements of [section 3]; and

(g) unequivocally provide that the charges for medical services not included in the agreement are the sole responsibility of the patient.

(4) A direct patient care agreement may allow for the direct fee and any additional fees to be paid by a third party.

(5) (a) Either party to a direct patient care agreement may terminate the agreement in writing without penalty or payment of a termination fee:

(i) at any time; or

(ii) after notice as specified in the agreement. The notice requirement may not exceed 60 days.

(b) The agreement must specify the terms of cancellation, including terms that cover relocation or military duty by the patient.

Section 3. Disclosure required. A direct patient care agreement must prominently display a written disclaimer that is either printed on or accompanies all application and guideline materials distributed by or on behalf of the agreement. The disclaimer must read substantially as follows:

Notice: The organization facilitating the direct patient care agreement is not an insurance company, and the direct patient care company guidelines and agreement operation are not an insurance policy. The agreement does not meet any individual health insurance mandate that may be required by federal law. Participation in the direct patient care agreement or a subscription to any of its documents should not be considered to be a health insurance policy. Regardless of whether you receive treatment for medical issues through the direct patient care agreement, you are always personally responsible for the payment of any additional medical expenses that you may incur.

Section 4. Interference prohibited. (1) A licensing board for a health care provider or another state agency may not prohibit, interfere with, initiate a legal or administrative proceeding against, or impose a fine or penalty against:

- (a) a health care provider solely because the provider provides direct patient care; or
- (b) a person solely because the person pays a direct fee for direct patient care.

(2) A health insurance issuer as defined in 33-22-140 or a health care provider may not prohibit, interfere with, initiate a legal or administrative proceeding against, or impose a fine or penalty against:

- (a) a health care provider solely because the provider provides direct patient care; or
- (b) a person solely because the person pays a direct fee for direct patient care.

Section 5. Section 30-14-102, MCA, is amended to read:

"30-14-102. Definitions. As used in this part, the following definitions apply:

(1) "Consumer" means a person who purchases or leases goods, services, real property, or information primarily for personal, family, or household purposes.

(2) "Department" means the department of justice created in 2-15-2001.

(3) "Documentary material" means the original or a copy of any book, record, report, memorandum, paper, communication, tabulation, map, chart, photograph, mechanical transcription, or other tangible

document or recording.

(4) "Examination" of documentary material includes the inspection, study, or copying of documentary material and the taking of testimony under oath or acknowledgment in respect to any documentary material or copy of documentary material.

(5) (a) "Gift certificate" means a record, including a gift card or stored value card, that is provided for paid consideration and that indicates a promise by the issuer or seller of the record that goods or services will be provided to the possessor of the record for the value that is shown on the record or contained within the record by means of a microprocessor chip, magnetic stripe, bar code, or other electronic information storage device. The consideration provided for the gift certificate must be made in advance. The value of the gift certificate is reduced by the amount spent with each use. A gift certificate is considered trust property of the possessor if the issuer or seller of the gift certificate declares bankruptcy after issuing or selling the gift certificate. The value represented by the gift certificate belongs to the possessor, to the extent provided by law, and not to the issuer or seller.

(b) The term does not include:

(i) prepaid telecommunications and technology cards, including but not limited to prepaid telephone calling cards, prepaid technical support cards, and prepaid internet disks that have been distributed to or purchased by a consumer;

(ii) a coupon provided to a consumer pursuant to any award, loyalty, or promotion program without any money or consideration being given in exchange for the card; or

(iii) a gift certificate usable with multiple sellers of goods or services.

(6) "Person" means natural persons, corporations, trusts, partnerships, incorporated or unincorporated associations, and any other legal entity.

(7) "Possessor" means a natural person who has physical control over a gift certificate.

(8) (a) "Trade" and "commerce" mean the advertising, offering for sale, sale, or distribution of any services, any property, tangible or intangible, real, personal, or mixed, or any other article, commodity, or thing of value, wherever located, and includes any trade or commerce directly or indirectly affecting the people of this state.

(b) The terms include direct patient care agreements established pursuant to [section 11]."

Section 6. Section 33-1-102, MCA, is amended to read:

"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs -- service contracts. (1) A person may not transact a business of insurance in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) The provisions of this code do not apply with respect to:

- (a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;
- (b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and
- (c) fraternal benefit societies, except as stated in chapter 7.

(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and operations of those organizations are governed by chapter 31.

(5) This code does not apply to workers' compensation insurance programs provided for in Title 39, chapter 71, part 21, and related sections.

(6) The department of public health and human services may limit the amount, scope, and duration of services for programs established under Title 53 that are provided under contract by entities subject to this title. The department of public health and human services may establish more restrictive eligibility requirements and fewer services than may be required by this title.

(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8, or the Montana university system group benefits plans established in Title 20, chapter 25, part 13.

(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

(9) (a) Except as otherwise provided in Title 33, chapters 22 and 28, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention,

deductible, or self-insurance plan.

(b) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in which the political subdivision provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded program.

(10) (a) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making of, proposal to make, and administration of a service contract.

(b) A "service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair, replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service. A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from power surges or accidental damage from handling. A service contract does not include motor club service as defined in 61-12-301.

(11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for the financial risk under the contract with the third party as provided in 7-34-103.

(b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or town, the entity is subject to the provisions of this code.

(12) This code does not apply to the self-insured student health plan established in Title 20, chapter 25, part 14.

(13) Except as provided in 33-2-2212, this code does not apply to private air ambulance services that are in compliance with 50-6-320 and that solicit membership subscriptions, accept membership applications, charge membership fees, and provide air ambulance services to subscription members and designated members of their households.

(14) This code does not apply to guaranteed asset protection waivers that are governed by Title 30, chapter 14, part 22.

(15) This code does not apply to direct patient care agreements established pursuant to [section 1]."

Section 7. Section 33-1-201, MCA, is amended to read:

"33-1-201. Definitions -- insurance in general. For the purposes of this code, the following definitions apply unless the context requires otherwise:

(1) "Alien insurer" is an insurer formed under the laws of any country other than the United States or its states, districts, territories, and commonwealths.

(2) "Authorized insurer" is an insurer duly authorized by a certificate of authority issued by the commissioner to transact insurance in this state.

(3) "Domestic insurer" is an insurer incorporated under the laws of this state.

(4) "Foreign insurer" is an insurer formed under the laws of any jurisdiction other than this state.

Except when distinguished by context, the term includes an alien insurer.

(5) (a) "Insurance" is a contract through which one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies.

(b) ~~insurance~~ The term does not include:

(i) __contracts for the installation, maintenance, and provision of inside telecommunications wiring to residential or business premises; or

(ii) direct patient care agreements established pursuant to [section 1].

(6) "Insurer" includes every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance. The term also includes a health service corporation in the provisions listed in 33-30-102.

(7) "Resident domestic insurer" is an insurer incorporated under the laws of this state and:

(a) if a mutual company, not less than one-half of the policyholders are individuals who are residents of this state; or

(b) if a stock insurer, not less than one-half of the shares are owned by individuals who are residents of this state and all of the directors and officers of the insurer are residents of this state.

(8) "State", when used in relation to jurisdiction, means a state, the District of Columbia, or a territory, commonwealth, or possession of the United States.

(9) "Transact", with respect to insurance, means to:

- (a) solicit;
- (b) negotiate;
- (c) sell or effectuate a contract of insurance; or
- (d) transact matters subsequent to effectuation of the contract of insurance and arising out of it.

(10) "Unauthorized insurer" is an insurer not authorized by a certificate of authority issued by the commissioner to transact insurance in this state."

Section 8. Section 33-1-207, MCA, is amended to read:

"33-1-207. Disability insurance. (1) Disability insurance, including credit disability insurance, is insurance of human beings:

(a) against bodily injury, disablement, or death by accident or accidental means or the medical expense or indemnity involved; or

(b) against disablement or medical expense or indemnity resulting from sickness.

(2) Transaction of disability insurance does not include:

(a) workers' compensation insurance; or

(b) a direct patient care agreement established pursuant to [section 1]."

Section 9. Section 33-22-140, MCA, is amended to read:

"33-22-140. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Beneficiary" has the meaning given the term by 29 U.S.C. 1002(33).

(2) "Church plan" has the meaning given the term by 29 U.S.C. 1002(33).

(3) "COBRA continuation provision" means:

(a) section 4980B of the Internal Revenue Code, 26 U.S.C. 4980B, other than subsection (f)(1) of that section as that subsection relates to pediatric vaccines;

(b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.; or

- (c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.
- (4) (a) "Creditable coverage" means coverage of the individual under any of the following:
 - (i) a group health plan;
 - (ii) health insurance coverage;
 - (iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4;
 - (iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;
 - (v) Title 10, chapter 55, United States Code;
 - (vi) a medical care program of the Indian health service or of a tribal organization;
 - (vii) a health plan offered under Title 5, chapter 89, of the United States Code;
 - (viii) a public health plan;
 - (ix) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); or
 - (x) a high-risk pool in any state.
- (b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.
- (5) "Dependent" means:
 - (a) a spouse;
 - (b) an unmarried child under 25 years of age:
 - (i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;
 - (ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance;
 - (iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and
 - (iv) for whom the insured parent has requested coverage;
 - (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or
 - (d) any other individual defined as a dependent in the health benefit plan covering the employee.

(6) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific condition that would otherwise be covered under the policy.

(7) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment.

(8) "Excepted benefits" means:

- (a) coverage only for accident or disability income insurance, or both;
- (b) coverage issued as a supplement to liability insurance;
- (c) liability insurance, including general liability insurance and automobile liability insurance;
- (d) workers' compensation or similar insurance;
- (e) automobile medical payment insurance;
- (f) credit-only insurance;
- (g) coverage for onsite medical clinics;
- (h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits, as approved by the commissioner;
 - (i) if offered separately, any of the following:
 - (i) limited-scope dental or vision benefits;
 - (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these types of care; or
 - (iii) other similar, limited benefits as approved by the commissioner;
 - (j) if offered as independent, noncoordinated benefits, any of the following:
 - (i) coverage only for a specified disease or illness; or
 - (ii) hospital indemnity or other fixed indemnity insurance;
 - (k) if offered as a separate insurance policy:
 - (i) medicare supplement coverage;
 - (ii) coverage supplemental to the coverage provided under Title 10, chapter 55, of the United States Code; and
 - (iii) similar supplemental coverage provided under a group health plan.

(9) "Federally defined eligible individual" means an individual:

(a) for whom, as of the date on which the individual seeks coverage in the group market or individual market, the aggregate of the periods of creditable coverage is 18 months or more;

(b) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any of those plans;

(c) who is not eligible for coverage under:

(i) a group health plan;

(ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4; or

(iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor program;

(d) who does not have other health insurance coverage;

(e) for whom the most recent coverage within the period of aggregate creditable coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(f) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected that coverage; and

(g) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (9)(f) if the individual elected the continuation coverage described in subsection (9)(f).

(10) "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.

(11) "Group health plan" means an employee welfare benefit plan, as defined in 29 U.S.C. 1002(1), to the extent that the plan provides medical care and items and services paid for as medical care to employees or their dependents, directly or through insurance, reimbursement, or otherwise.

(12) "Health insurance coverage" means benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health care services agreement offered by a health insurance issuer.

(13) (a) "Health insurance issuer" means an insurer, a health service corporation, or a health

maintenance organization.

(b) The term does not include a direct patient care agreement established pursuant to [section 1].

(14) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(15) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with group health insurance coverage.

(16) "Large employer" means, in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(17) "Large group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan or group health insurance coverage issued to a large employer.

(18) "Late enrollee" means an eligible employee or dependent, other than a special enrollee under 33-22-523, who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent is not considered a late enrollee if a court has ordered that coverage be provided for a spouse, minor, or dependent under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(19) "Medical care" means:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) transportation primarily for and essential to medical care referred to in subsection (19)(a); or

(c) insurance covering medical care referred to in subsections (19)(a) and (19)(b).

(20) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(21) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

(22) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on presence of a condition before the enrollment date coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date.

(23) "Small group market" means the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan or group health insurance coverage maintained by a small employer as defined in 33-22-1803.

(24) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan."

Section 10. Section 33-30-101, MCA, is amended to read:

"33-30-101. Definitions. As used in this chapter, the following definitions apply:

(1) (a) "Health service corporation" means a nonprofit corporation organized or operating for the purposes of establishing and operating a nonprofit plan or plans under which prepaid hospital care, medical-surgical care, and other health care and services, or reimbursement ~~therefor~~ for the preceding care and services, may be furnished to a member or beneficiary.

(b) The term does not include a direct patient care agreement established pursuant to [section 1].

(2) "Health services" means the health care and services provided by hospitals or other health care institutions, organizations, associations, or groups and by doctors of medicine, osteopathy, dentistry, chiropractic, optometry, and podiatry; nursing services; licensed acupuncturist services; licensed social worker, licensed professional counselor, or psychologist services; medical appliances, equipment, and supplies; and drugs, medicines, ambulance services, and other therapeutic services and supplies.

(3) "Membership contract" means any agreement, contract, or certificate by which a health service corporation describes the health services or benefits provided to its members or beneficiaries."

Section 11. Section 33-31-102, MCA, is amended to read:

"33-31-102. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

- (1) "Accountable care organization" means a group of health care providers that are willing and capable of accepting accountability for the total cost and quality of care for a defined population.
- (2) "Affiliation period" means a period that, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective.
- (3) "Basic health care services" means:
 - (a) consultative, diagnostic, therapeutic, and referral services by a provider;
 - (b) inpatient hospital and provider care;
 - (c) outpatient medical services;
 - (d) medical treatment and referral services;
 - (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to 33-31-301(3)(e);
 - (f) care and treatment of mental illness, alcoholism, and drug addiction;
 - (g) diagnostic laboratory and diagnostic and therapeutic radiologic services;
 - (h) preventive health services, including:
 - (i) immunizations;
 - (ii) well-child care from birth;
 - (iii) periodic health evaluations for adults;
 - (iv) voluntary family planning services;
 - (v) infertility services; and
 - (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction;
 - (i) minimum mammography examination, as defined in 33-22-132;
 - (j) outpatient self-management training and education for the treatment of diabetes along with certain diabetic equipment and supplies as provided in 33-22-129; and
 - (k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have the meanings provided for in 33-22-131.

(4) "Commissioner" means the commissioner of insurance of the state of Montana.

(5) "Dependent" has the meaning provided in 33-22-140.

(6) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

(7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(8) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

(9) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(10) (a) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers. This subsection (10) does not limit methods of provider payments made by health maintenance organizations.

(b) The term does not apply to:

(i) a PACE organization or an accountable care organization that has received a waiver pursuant to 33-31-201; or

(ii) a direct patient care agreement established pursuant to [section 1].

(11) "Insurance producer" means an individual or business entity appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(12) "PACE organization" means an organization, as defined in 42 CFR 460.6, that is authorized by

the centers for medicare and medicaid services and the department of public health and human services to operate a program of all-inclusive care for the elderly.

(13) "Person" means:

- (a) an individual;
- (b) a group of individuals;
- (c) an insurer, as defined in 33-1-201;
- (d) a health service corporation, as defined in 33-30-101;
- (e) a corporation, partnership, facility, association, or trust; or
- (f) an institution of a governmental unit of any state licensed by that state to provide health care,

including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(14) "Plan" means a health maintenance organization operated by an insurer or health service corporation as an integral part of the corporation and not as a subsidiary.

(15) "Point-of-service option" means a delivery system that permits an enrollee of a health maintenance organization to receive health care services from a provider who is, under the terms of the enrollee's contract for health care services with the health maintenance organization, not on the provider panel of the health maintenance organization.

(16) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or advanced practice registered nurse, as specifically listed in 37-8-202, or registered nurse first assistant as defined by the board of nursing under Title 37, chapter 8, who treats any illness or injury within the scope and limitations of the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

(17) "Provider panel" means those providers with whom a health maintenance organization contracts to provide health care services to the health maintenance organization's enrollees.

(18) "Purchaser" means the individual, employer, or other entity, but not the individual certificate holder in the case of group insurance, that enters into a health care services agreement.

(19) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes

insolvent."

Section 12. Section 50-4-105, MCA, is amended to read:

"50-4-105. Limitations of provider agreements -- exception. (1) Notwithstanding any other provision of law, a provider who has entered into a provider agreement with a person as defined in 33-1-202 is not required to provide a discount or accept payment at the rate agreed to in the provider agreement for health care services that are provided to an insured individual if the payment for the services is made directly or indirectly or is otherwise required to be made:

- (a) under casualty insurance as described in 33-1-206; or
- (b) under property insurance as described in 33-1-210.

(2) Insurance payments made to a provider of health care services under subsection (1) must be paid according to the terms of the applicable policy or in accordance with any written agreement or contract existing between the provider and the insurer or a person contractually engaged by the insurer to perform services or an insurance function for the insurer. This section does not prohibit negotiations regarding the amount of the billed charges or a reasonable request for additional information or documents in order to evaluate the claim.

(3) An insurer making payment on a claim under a disability insurance policy, member contract, health benefit plan, group health plan, blanket disability insurance policy as defined in 33-22-601, or other medical coverage shall credit toward satisfaction of the insured's deductible, copayment, or coinsurance, if any, any payment made by a casualty or property insurer but only if the payment to be credited is applied to a covered medical expense under the terms of the applicable health policy.

(4) The provisions of this section apply regardless of whether the insured may be considered a third-party beneficiary of the provider agreement.

(5) The provisions of this section do not apply to a direct patient care agreement established pursuant to [section 1]."

Section 13. Codification instruction. [Sections 1 through 4] are intended to be codified as an integral part of Title 50, chapter 4, part 1, and the provisions of Title 50, chapter 4, part 1, apply to [sections 1 through 4].

- END -

I hereby certify that the within bill,
SB 101, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day
of _____, 2021.

Speaker of the House

Signed this _____ day
of _____, 2021.

SENATE BILL NO. 101

INTRODUCED BY C. SMITH

AN ACT AUTHORIZING DIRECT PATIENT CARE AGREEMENTS; ESTABLISHING REQUIREMENTS FOR DIRECT PATIENT CARE AGREEMENTS; ESTABLISHING THAT DIRECT PATIENT CARE AGREEMENTS ARE NOT HEALTH INSURANCE; MAKING DIRECT PATIENT CARE AGREEMENTS SUBJECT TO CONSUMER PROTECTION LAWS; AND AMENDING SECTIONS 30-14-102, 33-1-102, 33-1-201, 33-1-207, 33-22-140, 33-30-101, 33-31-102, AND 50-4-105, MCA.