AN ACT REQUIRING TRANSPARENCY IN PRICING OF HEALTH CARE SERVICES; REQUIRING COST DISCLOSURES BY HEALTH CARE PROVIDERS AND HEALTH INSURERS; REQUIRING HEALTH INSURERS TO OFFER TRANSPARENCY TOOLS FOR HEALTH CARE CONSUMERS; REQUIRING PUBLIC EMPLOYEE GROUP BENEFIT PLANS TO COMPLY WITH TRANSPARENCY REQUIREMENTS; PROVIDING PENALTIES; PROVIDING DEFINITIONS; AMENDING SECTIONS 2-18-702, 2-18-811, 20-25-1303, 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 EFFECTIVE DATES.

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

Section 1. Transparency in health care services -- legislative intent. (1) The legislature finds health care consumers often do not have the information needed to make responsible, cost-effective decisions about the health care services they receive.

(2) The legislature further finds that consumers are more likely to make good decisions about health care services when they have complete information about the potential costs of care.

(3) The legislature further finds that the use of health care payment information could stabilize or reduce the costs of health care services.

(4) It is the intent of the legislature to make the costs of health care services and the performance of health care providers more transparent to health care consumers.

Section 2. Definitions. As used in [sections 1 through 4], the following definitions apply:

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

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

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

(2) "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 provider" means:

(a) an individual who is licensed under chapters 3, 7, 8, 12, 20, or 26 of Title 37; 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.

(6) "Health care service" means a nonemergency covered service, procedure, or treatment for which a health insurer or health plan makes cost information available through a transparency tool.

(7) "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.

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

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

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

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

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

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

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

(b) provides quality ratings or measures, if available, for health care providers who offer the health service; and

(c) provides information on potential out-of-network costs and the insured's out-of-network cost-sharing responsibilities.

(2) The transparency tool must allow covered individuals to easily obtain, with minimal navigation, the information required under this section.

(3) The transparency tool must provide costs for health care services based on factors determined by insurers including but not limited to:

(a) the number of in-network health care providers that offer the health care service; and

(b) the cost variance between the health care providers for the health care service.

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

(5) An individual who obtains insurance coverage in an effort to use the transparency tool to gain access to the rates an insurer or health plan has negotiated with a health care provider commits the act of insurance fraud as defined in 33-1-1202 and is subject to the penalty provided for in 33-1-1211.

Section 5. Section 2-18-702, MCA, is amended to read:

"2-18-702. Group insurance for public employees and officers. (1) (a) Except as provided in subsection (1)(c), all counties, cities, towns, school districts, and the board of regents shall upon approval by two-thirds vote of their respective officers and employees enter into group hospitalization, medical, health, including long-term disability, accident, or group life insurance contracts or plans for the benefit of their officers and employees and their dependents. The laws prohibiting discrimination on the basis of marital status in Title 49 do not prohibit bona fide group insurance plans from providing greater or additional contributions for insurance benefits to employees with dependents than to employees without dependents or with fewer dependents.

(b) The governing body of a county, city, or town may, at its discretion, consider the employees of

private, nonprofit economic development organizations, hospitals, health centers, or nursing homes to be employees of the county, city, or town solely for the purpose of participation in group hospitalization, medical, health, including long-term disability, accident, or group life insurance contracts or plans as provided in subsection (1)(a). The governing body of the county, city, or town may require an employee, organization, hospital, health center, or nursing home to pay the actual cost of coverage required for participation or may, at its discretion and subject to any restriction on who may be a member of a group, pay all or part of the cost of coverage of the employee of the organization.

(c) The governing body of a county having a taxable valuation of less than $30 million or the board of trustees of a hospital district may, at its discretion, exempt employees of a county hospital, county rest home or nursing home, or hospital district from participation in group hospitalization, medical, health, including long-term disability, accident, or group life insurance contracts or plans provided pursuant to subsection (1)(a) or (1)(b).

(2) State employees and elected officials, as defined in 2-18-701, may participate in state employee group benefit plans as are provided for under part 8 of this chapter.

(3) For state officers and employees, the premiums required from time to time to maintain the insurance in force must be paid by the insured officers and employees, and the state treasurer shall deduct the premiums from the salary or wages of each officer or employee who elects to become insured, on the officer's or employee's written order, and issue a warrant for the premiums to the insurer.

(4) For the purpose of this section, the plans of health service corporations for defraying or assuming the cost of professional services of licensees in the field of health or the services of hospitals, clinics, or sanitariums or both professional and hospital services must be construed as group insurance and the dues payable under the plans must be construed as premiums for group insurance.

(5) If the board of trustees of a school district implements a self-insured group health plan or if the board of regents implements an alternative to conventional insurance to provide group benefits to its employees, the board shall maintain the alternative plan on an actuarially sound basis.

(6) Contracts or plans offered under this section must meet the requirements of [sections 1 through 4]."

Section 6. Section 2-18-811, MCA, is amended to read:

"2-18-811. General duties of department. (1) The department shall:

~~(1)~~(a) adopt rules for the conduct of its business under this part and to carry out the purposes of this part;

~~(2)~~(b) negotiate and administer contracts for state employee group benefit plans for a period not to exceed 10 years;

~~(3)~~(c) design state employee group benefit plans, establish specifications for bids, and make recommendations for acceptance or rejection of bids;

~~(4)~~(d) prepare an annual report that describes the state employee group benefit plans being administered, details the historical and projected program costs and the status of reserve funds, and makes recommendations, if any, for change in existing state employee group benefit plans;

~~(5)~~(e) prior to each legislative session, perform or obtain an analysis of rate adequacy of all state employee group benefit plans administered under this part; and

~~(6)~~(f) submit the report required in this section to the office of budget and program planning as a part of the information required by 17-7-111.

(2) The department shall comply with the requirements of [sections 1 through 4] for the state employee group benefit plans offered under this part."

Section 7. Section 20-25-1303, MCA, is amended to read:

"20-25-1303. Duties of commissioner -- group benefits plans and employee premium levels not mandatory subjects for collective bargaining. (1) The commissioner shall:

(a) design group benefits plans and establish premium levels for employees;

(b) establish specifications for bids and accept or reject bids for administering group benefits plans;

(c) negotiate and administer contracts for group benefits plans;

(d) prepare an annual report that:

(i) describes the group benefits plans being administered; and

(ii) details the historical and projected program costs and the status of reserve funds; and

(e) adopt policies for the conduct of business of the advisory committee and to carry out the provisions of this part.

(2) The provisions of Title 33 do not apply to the commissioner when exercising the duties provided for in this part.

(3) The design or modification of group benefits plans and the establishment of employee premium levels are not mandatory subjects for collective bargaining under Title 39, chapter 31.

(4) The commissioner shall comply with the requirements of [sections 1 through 4] for the group benefits plans offered under this part."

Section 8. 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 and [sections 1 through 4] 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, 33-22-150 through 33-22-152, and 33-22-301 apply to group or blanket policies."

Section 9. Section 33-28-207, MCA, is amended to read:

"33-28-207. Applicable laws. (1) The following apply to captive insurance companies:

(a) the definitions of commissioner and department provided in 33-1-202, property insurance provided in 33-1-210, casualty insurance provided in 33-1-206, life insurance provided in 33-1-208, health insurance coverage and group health plans provided in 33-22-140, and disability income insurance provided in 33-1-235;

(b) the limitation provided in 33-2-705 on the imposition of other taxes;

(c) the provisions relating to supervision, rehabilitation, and liquidation of insurance companies as provided for in Title 33, chapter 2, part 13;

(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;

(e) the provisions relating to dissolution and liquidation in Title 33, chapter 3, part 6, except that a pure captive insurance company may proceed with voluntary dissolution and liquidation after prior notice to and approval of the commissioner without following the provisions of Title 33, chapter 3, part 6; and

(f) the authority of the commissioner under 33-2-701(6) to impose a fine for failure to timely file an annual statement, except that the annual statement requirements in 33-28-107 apply.

(2) This chapter may not be construed as exempting a captive insurance company, its parent, or affiliated companies from compliance with the laws governing workers' compensation insurance.

(3) A captive insurance company or branch captive insurance company that writes health insurance coverage or group health plans as defined in 33-22-140 shall comply with applicable state and federal laws, including but not limited to [sections 1 through 4].

(4) The following provisions apply to captive risk retention groups:

(a) those relating to actuarial opinions in Title 33, chapter 1, part 14;

(b) those relating to risk-based capital in Title 33, chapter 2, part 19; and

(c) those relating to insurance holding company systems in Title 33, chapter 2, part 11.

(5) Except as expressly provided in this chapter, the provisions of Title 33 do not apply to captive insurance companies."

Section 10. Section 33-35-306, MCA, is amended to read:

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

(a) 33-1-111;

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

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

(d) 33-3-308;

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

(f) Title 33, chapter 19;

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

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

(i) [sections 1 through 4]; and

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

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

Section 11. 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 12. Section 50-4-504, MCA, is amended to read:

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

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

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

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

(2) "Estimate of total charges" means:

(a) a comprehensive estimate of the charges for all elements of a health care service if the service is being provided by:

(i) a physician;

(ii) any other type of health care provider as defined in subsection (4)(a) who is employed by a facility listed in subsection (4)(b); or

(iii) a health care provider as defined in subsection (4)(b); or

(b) the charge for an individual health care provider's health care service if the provider meets the definition of subsection (4)(a) and is not employed by a facility listed in subsection (4)(b).

~~(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.

(5) "Health care service" means a nonemergency service, procedure, or treatment offered by a health care provider.

~~(3)~~(6) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities."

Section 13. Section 50-4-512, MCA, is amended to read:

"50-4-512. Disclosures required of health care providers. (1) Upon written request of a patient or ~~a patient's~~ an authorized agent, a health care provider~~, outpatient center for surgical services, clinic, or hospital~~ shall provide the patient or the ~~patient's~~ agent with ~~its estimated charge~~ a comprehensive, good-faith estimate of total charges for a health care service or course of treatment that exceeds ~~$500~~ $500. The estimate must be provided for a health care 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~~ the following timeframes upon receipt of the written request and of any additional information needed to provide a comprehensive estimate of total charges:

(a) 5 business days for a health care provider with more than five full-time employees; and

(b) 10 business days for a health care provider with five or fewer full-time employees.

(2) The estimate of total charges must:

(a) indicate network status, if known, under an insured patient's health plan; and

(b) if known, indicate whether the services of other health care providers may be necessary to complete the health care service or course of treatment being provided or recommended by the health care provider and inform the patient that an estimate of those charges and information on network status must be obtained separately from the other health care providers or another health plan.

(3) If the patient is uninsured, the health care provider shall:

(a) include in the total cost estimate any financial assistance available to the patient from the health care provider; and

(b) direct the patient or the agent to websites, if available, that provide information about standard charges for the type of health care provider involved in the health care service.

~~(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~~ estimate of total charges:

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

(7) (a) A patient who believes a health care provider has failed to adhere to the requirements of this section may file a written complaint with the department of public health and human services.

(b) If the department of public health and human services determines that a violation of this section has occurred, the department may fine the provider up to 5% of the disputed amount, not to exceed $500 per occurrence. Fines collected pursuant to this section must be deposited in the general fund."

Section 14. Section 50-4-518, MCA, is amended to read:

"50-4-518. Disclosures required of health insurers -- limitations. (1) When requested by an insured or ~~the insured's~~ an authorized 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 an estimate of total charges by a

health care provider~~, outpatient center for surgical services, clinic, or hospital~~ exceeds ~~$500~~ $250.

(2) The request by the insured or ~~insured's~~ the authorized agent ~~may request that~~ for the information required under this section must be ~~provided~~ made by phone, in writing, or electronically.

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

~~(3)~~(4) 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."

Section 15. Codification instruction. [Sections 1 through 4] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 4].

Section 16. Coordination instruction. (1) If both House Bill No. 123 and [this act] are passed and approved, then House Bill No. 123 is void.

(2) If both House Bill No. 612 and [this act] are passed and approved, then [section 2(5) of this act] must read as follows:

"(5) "Health care provider" means:

(a) a physician who is licensed under Title 37, chapter 3, to practice medicine in this state;

(b) an individual who is licensed under chapters 7, 8, 12, 20, or 26 of Title 37; and

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

Section 17. Effective dates. (1) Except as provided in subsection (2), [this act] is effective January 1, 2019.

(2) [Sections 11 through 14] and this section are effective October 1, 2017.

- END -

I hereby certify that the within bill,

SB 0362, originated in the Senate.

President of the Senate

Signed this _____ day

of _____, 2017.

Secretary of the Senate

Speaker of the House

Signed this _____ day

of _____, 2017.

SENATE BILL NO. 362

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

AN ACT REQUIRING TRANSPARENCY IN PRICING OF HEALTH CARE SERVICES; REQUIRING COST DISCLOSURES BY HEALTH CARE PROVIDERS AND HEALTH INSURERS; REQUIRING HEALTH INSURERS TO OFFER TRANSPARENCY TOOLS FOR HEALTH CARE CONSUMERS; REQUIRING PUBLIC EMPLOYEE GROUP BENEFIT PLANS TO COMPLY WITH TRANSPARENCY REQUIREMENTS; PROVIDING PENALTIES; PROVIDING DEFINITIONS; AMENDING SECTIONS 2-18-702, 2-18-811, 20-25-1303, 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 EFFECTIVE DATES AND AN APPLICABILITY DATE.