AN ACT ESTABLISHING HOLD HARMLESS REQUIREMENTS FOR PATIENTS AND DISPUTE RESOLUTION PROCESSES FOR AIR AMBULANCE PROVIDERS AND INSURERS; PROVIDING DISCLOSURES BY AIR AMBULANCE SERVICES; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 20-25-1403, 33-30-102, 33-31-111, AND 33-35-306, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY DATE.

WHEREAS, House Joint Resolution No. 29 (2015) requested a study of the availability, billing practices, and insurer network participation of air ambulance services; and

WHEREAS, the study revealed significant gaps between some air ambulances' billed charges and some insurers' reimbursement rates; and

WHEREAS, these gaps have resulted in some air ambulance patients receiving crippling balance bills and in the proliferation of air ambulance subscription programs; and

WHEREAS, this problem is compounded by deficiencies in insurer networks with respect to air ambulances; and

WHEREAS, certain marketing tactics and a lack of subscription program reciprocity result in consumers purchasing air ambulance subscriptions that lack adequate coverage areas.

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

Section 1. Legislative findings and purpose. (1) The legislature finds that:

(a) air ambulance services provide a necessary, and sometimes lifesaving, means of transporting Montanans experiencing health emergencies;

(b) Montanans desire adequate access to air ambulance services;

(c) in many cases the high charges assessed by out-of-network air ambulance services and limited insurer and health plan reimbursements have resulted in Montanans incurring excessive out-of-pocket expenses; and

(d) the federal Airline Deregulation Act preempts states from enacting any law related to a price, route, or service of an air carrier, which is interpreted as applying to air ambulance services.

(2) The purpose of [sections 1 through 6] is to prevent Montanans from incurring excessive out-of-pocket expenses in out-of-network air ambulance situations in a manner that is not preempted by the Airline Deregulation Act.

Section 2. Hold harmless. (1) If a covered person receives services from a non-Montana hospital-controlled out-of-network air ambulance service for an emergency medical condition, an insurer or health plan shall assume the covered person's responsibility, if any, for amounts charged in excess of allowed amounts for covered services and supplies, applicable copayments, coinsurance, and deductibles.

(2) An insurer or health plan that assumes a responsibility pursuant to subsection (1) shall notify the air ambulance service of that assumption no later than the date the insurer or health plan issues payment under subsection (4).

(3) If an air ambulance service receives notice pursuant to subsection (2), with the exception of amounts owed for applicable copayments, coinsurance, and deductibles, the air ambulance service may not:

(a) bill, collect, or attempt to collect from the covered person for the responsibility assumed under subsection (1);

(b) report to a consumer reporting agency that the covered person is delinquent on the responsibility assumed under subsection (1); or

(c) obtain a lien on the covered person's property in connection with the responsibility assumed under subsection (1).

(4) (a) An insurer or health plan is responsible for payment or denial of a claim within 30 days after receipt of a proof of loss, except as provided in 33-18-232(1). Within the timeframe provided in this subsection (4)(a), the insurer or health plan shall notify the covered person of the amount of deductible, coinsurance, or copayment that is the covered person's responsibility to pay.

(b) The insurer or health plan responsible under subsection (1) shall make payment based on:

(i) the billed charges of the air ambulance service;

(ii) another amount negotiated with the air ambulance service; or

(iii) the median amount the insurer or health plan would pay to an in-network air ambulance service for the services performed.

(5) If after payment is made under subsection (4) the insurer or health plan and air ambulance service

dispute whether any further payment obligation exists, the insurer or health plan and air ambulance service shall enter into the dispute resolution process set forth in [sections 4 through 6]. After the independent dispute resolution process is exhausted, the aggrieved party may pursue any available remedies in a court of competent jurisdiction.

(6) For the purposes of this section:

(a) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a person who possesses knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(i) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part; and

(b) "insurer" means a health insurance issuer as defined in 33-22-140 and includes issuers of health insurance under Titles 2 and 20.

(7) [Sections 1 through 6] do not apply if a covered person used an air ambulance membership subscription, as provided in 50-6-320, for the services provided by the air ambulance service.

Section 3. Disclosures by air ambulance service. An out-of-network nonhospital-controlled air ambulance service must disclose by July 1 of each year any relationships or financial arrangements with health care providers, insurers, or health plans. This includes but is not limited to employment arrangements, ownership interests, first call agreements, and board memberships. This information must be filed with the department of public health and human services and also posted prominently on the commissioner of insurance's website. The air ambulance service must ensure the continued accuracy of this information throughout the year by submitting written updates within 5 days of any changes to the information.

Section 4. Independent dispute resolution. (1) If an insurer or health plan and air ambulance service enter into dispute resolution, the procedure in [section 5] is to be used to determine the fair market price of the services that are the subject of the claim.

(2) Payment of the fair market price calculated pursuant to [section 5] constitutes payment in full of the claim.

(3) A determination under this section is not binding on the insurer or health plan and the air ambulance

service.

(4) Unless otherwise agreed to by the parties, each party shall:

(a) bear its own attorney fees and costs incurred under the procedure provided in [section 5]; and

(b) equally bear all fees and costs of the independent reviewer.

(5) As used in this section, "fair market price" means the value of the services provided as determined by the independent reviewer based on the factors provided in [section 5(6)].

Section 5. Independent dispute resolution procedure -- exemptions. (1) To initiate a dispute resolution procedure under [sections 1 through 6], the parties shall file a written notice of dispute with the insurance commissioner.

(2) Except as provided in subsection (3), within 30 days after the date of receipt of the notice of dispute, and if no independent reviewer is mutually agreed to by the insurer or health plan and air ambulance service under subsection (3), the insurance commissioner shall appoint an independent reviewer having the qualifications listed in [section 6]. The insurance commissioner shall select an independent reviewer randomly from a list established under [section 6].

(3) The insurer or health plan and air ambulance provider may by mutual agreement select an independent reviewer. The parties shall notify the insurance commissioner of the mutually agreed independent reviewer prior to the appointment of an independent reviewer under subsection (2).

(4) An independent reviewer's sole substantive determination under this part is the fair market price of the services that are the subject of the claim.

(5) The independent reviewer may make procedural rulings necessary to regulate the proceedings.

(6) The factors to be used in the independent reviewer's determination are:

(a) the training, qualifications, and composition of the air ambulance service personnel;

(b) the fees for rotor wing or fixed wing services originating or provided entirely within the state of Montana that are:

(i) usually charged by the air ambulance service in Montana;

(ii) usually accepted as payment in full by the air ambulance service in Montana;

(iii) usually charged by other air ambulance services doing business in Montana;

(iv) usually accepted as payment in full by other air ambulance services doing business in Montana; and

(v) usually paid by the insurer or health plan for the service provided in Montana;

(c) whether the air ambulance service was provided in a rural or urban context;

(d) the applicable medicare rate of payment for the services that are the subject of the claim; and

(e) any other factors the independent reviewer determines to be relevant in determining fair market price in accordance with established precedent.

(7) Participation in a dispute resolution procedure under [sections 4 through 6] exempts an insurer from 33-18-201(6) and (8) and 33-18-232(2).

Section 6. Insurance commissioner duties -- independent reviewer qualifications. (1) The insurance commissioner shall:

(a) approve any independent reviewer that is eligible to adjudicate disputes under [sections 1 through 6];

(b) maintain a list of independent reviewers eligible to adjudicate disputes under [sections 1 through 6];

(c) terminate approval of an independent reviewer and remove the independent reviewer from the list of approved independent reviewers upon determining that an independent reviewer no longer meets the requirements to adjudicate disputes; and

(d) adopt rules necessary to implement [sections 1 through 6], including rules regarding discovery and other procedures regarding the dispute resolution process and eligibility of an independent reviewer.

(2) An individual is eligible to be an independent reviewer under [sections 1 through 6] if the individual is knowledgeable and experienced in applicable principles of contract and insurance law.

(3) In approving an individual as an independent reviewer, the insurance commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an independent dispute resolution procedure under [sections 4 and 5]. A conflict of interest includes but is not limited to an ownership or direct familial interest in an insurer, a health care provider, or an air ambulance service that may be involved in an independent dispute resolution procedure under [sections 4 and 5].

(4) In approving an individual as an independent reviewer, the insurance commissioner may not approve an individual who is currently serving in any matter as a hearing officer for the commissioner.

Section 7. Section 20-25-1403, MCA, is amended to read:

"20-25-1403. (Temporary) Authorization to establish self-insured health plan for students -- requirements -- exemption. (1) The commissioner may establish a self-insured student health plan for enrolled students of the system and their dependents, including students of a community college district. In developing

a self-insured student health plan, the commissioner shall:

(a) maintain the plan on an actuarially sound basis;

(b) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the plan; and

(c) deposit all reserve funds, contributions and payments, interest earnings, and premiums paid to the plan. The deposits must be expended for claims under the plan and for the costs of administering the plan, including but not limited to the costs of hiring staff, consultants, actuaries, and auditors, purchasing necessary reinsurance, and repaying debts.

(2) Prior to the implementation of a self-insured student health plan, the commissioner shall consult with affected parties, including but not limited to the board of regents and representatives of enrolled students of the system.

(3) A self-insured student health plan developed under this part is not responsible for and may not cover any services or pay any expenses for which payment has been made or is due under an automobile, premises, or other private or public medical payment coverage plan or provision or under a workers' compensation plan or program, except when the other payor is required by federal law to be a payor of last resort. The term "services" includes but is not limited to all medical services, procedures, supplies, medications, or other items or services provided to treat an injury or medical condition sustained by a member of the plan.

(4) The provisions of [sections 1 through 6] apply to any self-insured student health plan developed under this part.

~~(4)~~(5) Except for the provisions of Title 33, chapter 40, part 1, the provisions of Title 33 do not apply to the commissioner when exercising the duties provided for in this part. (Terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)

20-25-1403. (Effective January 1, 2018) Authorization to establish self-insured health plan for students -- requirements -- exemption. (1) The commissioner may establish a self-insured student health plan for enrolled students of the system and their dependents, including students of a community college district. In developing a self-insured student health plan, the commissioner shall:

(a) maintain the plan on an actuarially sound basis;

(b) maintain reserves sufficient to liquidate the unrevealed claims liability and other liabilities of the plan; and

(c) deposit all reserve funds, contributions and payments, interest earnings, and premiums paid to the plan. The deposits must be expended for claims under the plan and for the costs of administering the plan,

including but not limited to the costs of hiring staff, consultants, actuaries, and auditors, purchasing necessary reinsurance, and repaying debts.

(2) Prior to the implementation of a self-insured student health plan, the commissioner shall consult with affected parties, including but not limited to the board of regents and representatives of enrolled students of the system.

(3) A self-insured student health plan developed under this part is not responsible for and may not cover any services or pay any expenses for which payment has been made or is due under an automobile, premises, or other private or public medical payment coverage plan or provision or under a workers' compensation plan or program, except when the other payor is required by federal law to be a payor of last resort. The term "services" includes but is not limited to all medical services, procedures, supplies, medications, or other items or services provided to treat an injury or medical condition sustained by a member of the plan.

(4) The provisions of [sections 1 through 6] apply to any self-insured student health plan developed under this part.

~~(4)~~(5) The provisions of Title 33 do not apply to the commissioner when exercising the duties provided for in this part."

Section 8. Section 33-30-102, MCA, is amended to read:

"33-30-102. Application of this chapter -- construction of other related laws. (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: 33-2-1212; 33-3-307; 33-3-308; 33-3-401; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 2, part 19; [sections 1 through 6]; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 15, 18, 19, 22, and 32, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict, the provisions of this chapter prevail."

Section 9. 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, part 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, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, [sections 1 through 6], 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 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, 33-22-706, Title 33, chapter 32[, and Title 33, chapter 40, part 1,] apply to health maintenance organizations. (Bracketed language in (7) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

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) [sections 1 through 6];

~~(d)~~(e) 33-3-308;

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

~~(f)~~(g) Title 33, chapter 19;

~~(g)~~(h) 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)~~(i) 33-22-512, 33-22-515, 33-22-525, and 33-22-526; 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) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

Section 11. Codification instruction. (1) [Sections 1 through 6] are intended to be codified as an integral part of Title 2, chapter 18, part 7, and the provisions of Title 2, chapter 18, part 7, apply to [sections 1 through 6].

(2) [Sections 1 through 6] are intended to be codified as an integral part of Title 20, chapter 25, part 13, and the provisions of Title 20, chapter 25, part 13, apply to [sections 1 through 6].

(3) [Sections 1 through 6] are intended to be codified as an integral part of Title 33, chapter 2, and the provisions of Title 33, chapter 2, apply to [sections 1 through 6].

Section 12. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 13. Effective date. [This act] is effective on passage and approval.

Section 14. Applicability. [This act] applies to all air ambulance transports that occur on or after [the

effective date of this act].

- END -

I hereby certify that the within bill,

SB 0044, 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. 44

INTRODUCED BY G. VANCE

BY REQUEST OF THE ECONOMIC AFFAIRS INTERIM COMMITTEE

AN ACT ESTABLISHING HOLD HARMLESS REQUIREMENTS FOR PATIENTS AND DISPUTE RESOLUTION PROCESSES FOR AIR AMBULANCE PROVIDERS AND INSURERS; PROVIDING DISCLOSURES BY AIR AMBULANCE SERVICES; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 20-25-1403, 33-30-102, 33-31-111, AND 33-35-306, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY DATE.