MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Senator Dorothy Eck, Chair, on February 15, 1993, at 1:00 p.m.

ROLL CALL

Members Present:
Sen. Dorothy Eck, Chair (D)
Sen. Eve Franklin, Vice Chair (D)
Sen. Chris Christiaens (D)
Sen. Tom Hager (R)
Sen. Terry Klampe (D)
Sen. Kenneth Mesaros (R)
Sen. David Rye (R)

Members Excused: Sen. Tom Towe

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Laura Turman, Committee Secretary
Tom Gomez, Legislative Council

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: SB 291
Executive Action: SB 285 - continued to 2/17

HEARING ON SB 291

Opening Statement by Sponsor:

Sen. Steve Doherty, Senate District 20, said SB 291 is the result of problems the mental health community has been having in getting paid in a timely fashion for their services. SB 291 will do three things for utilization review. First, the review should be done by a peer. Second, insurers should not ask for additional information as a way of slowing payment for services. And, third, additional information should be limited to the information regarding the care and treatment, and this information should be confidential and anonymous.

Proponents' Testimony:

John Platt, clinical psychologist in Bozeman and President of the Montana Psychological Association, provided written testimony. (Exhibit #1). Mr. Platt also provided a health insurance claim form. (Exhibit #2)

Dr. Elizabeth Kohlstaedt, clinical psychologist, said that Montana is a "very small state." Individuals come to a therapist because of unbearable mental pain such as shame, guilt or humiliation, and it is imperative that these intimate details be kept private. One part of SB 291 is to keep the reasons an individual sees a therapist anonymous. Regarding peer review, Dr. Kohlstaedt said she wants individuals with the same sense of trust and the same educational background to review her patients' cases.

Carl Bodek, licensed professional counselor in Missoula, said he represents the Montana Clinical Mental Health Counselor's Association as the insurance oversight chairperson. Mr. Bodek said the insurance commissioner in Montana has already ruled that it is not necessary to sent a patient's entire files to an insurance company. However, the insurance companies do not follow this rule and counselors are still required to send in all their notes. This is a problem because they have to work with the insurance companies, not the insurance commissioner. Mr. Bodek said that notes are legal documents which belong to the client, and a court may subpoena those notes. A lot of the information in the notes is not necessary for the insurance company, and Mr. Bodek said he would not include information in a client's notes if he feels they will hurt the client. The result is, he is not doing his job with his clients. He urged the Committee to give SB 291 a do pass recommendation.

Elizabeth Dane, Executive Director of the Montana Chapter of the National Association of Social Workers, provided written testimony. (Exhibit #3)

Jim Smith, Montana Psychological Association, said it is time that the insurance industry recognize the competence of the mental health professionals and recognize the sensitive nature of the work they do. Policies and procedures must be put in place which reflect this. The Association supports SB 291.

Kathy McGowan, Montana Counselor and Mental Health Centers, said they support SB 291 for the reasons already articulated.

Opponents' Testimony:

Tom Hopgood, Health Insurance Association of America, said that during the last legislative session there was a utilization review bill heard before the Senate Business and Industry Committee, which resulted in the enactment of Chapter 32 of Title 33 of the Insurance Code of Montana. In this, there are some details for the provisions for the conduct of utilization review.

Mr. Hopgood said that every time a "cost containment" bill comes before the legislature, there are providers who do not like those measures. SB 291, as it is written, is an "anti-cost containment measure." Mr. Hopgood suggested that the provisions used for the chiropractors during the last legislative session are suitable for this situation. He said that he and Jim Smith had discussed this, and there may be agreement. Upon the denial of benefits based on medical necessity or appropriateness of treatment, the entire claim would be reviewed again by an individual who is trained in that field. A separate review is also possible, and there could be a provision that the insurer would have to consider the second review. Regarding disclosure, his association has no problems with keeping the identity of the claim holder confidential, but he suggested that Section 33-19-306 already addresses this problem. The Association has no problems with the sections of SB 291 which address the amount of information necessary for review. Mr. Hopgood said he thought an accord could be reached on this bill.

Larry Akey, Montana Association of Life Underwriters, said that "cost containment" has become a "buzz word" for health care reforms nation-wide and in the Montana Legislature. Utilization review is one of the few ways insurers can review costs, and efforts to restrict utilization review take away one of the most important cost containment tools in the system. The Association does not believe there should be "broad disclosure," but they also believe that it is not necessary for a licensed psychologist to look at the records submitted to health insurance companies. Mr. Akey said there was a good solution arrived at last session regarding chiropractors, and he urged the Committee to look at that solution. There is no question that some portion of medical care provided is inappropriate or unnecessary, and the only way to control this is through utilization review. Mr. Akey urged the Committee to give SB 291 a do not pass recommendation for this reason.

Mary Dalton, Bureau Chief of the Medicaid Division of the Department of SRS, read testimony from Peter Blouke, Director of the Department SRS. (Exhibit #4)

Questions From Committee Members and Responses:

Sen. Christiaens asked Sen. Doherty for his response to putting a penalty section into SB 291 regarding confidentiality. Sen. Doherty said supports a penalty provision, but in many ways "the genie is already out of the bottle," and the damage is done. The information in question could "destroy a person" and block the success of their therapy.

Sen. Christiaens asked if lack of confidentiality was currently a wide-spread issue. Dr. Kohlstaedt said one of the problems is that patients don't know. Often, this applies to the poor because wealthy individuals can afford to skip insurance

companies all together. Dr. Kohlstaedt said she sees this happening because patients don't trust the insurance companies.

Carl Bodek said that every company handles its mail differently. He said he knew of instances where files sit out on desks for many days. Counselors have no control over how information is handled once it gets to an insurance company.

Sen. Christiaens said that patients have signed an authorization, and once it leaves the counselor, it is the responsibility of the insurance company. Sen. Christiaens said he would like someone from the insurance industry to comment. Tom Hopgood said 33-19-306 references insurance company's disclosure of information. Mr. Hopgood said that from what he's seen, he cannot conclude that lack of confidentiality is a problem.

Sen. Franklin asked Mr. Hopgood if individuals who work in sensitive areas have any training regarding the ethical nature of confidentiality associated with what they do. Mr. Hopgood said he was generalizing, but that everyone was "warned." In most companies, confidential information is not discussed. He didn't know if all companies had a standard warning.

Sen. Franklin said that her point was that there was a lot of variation in the degree to which the material is handled.

Chairman Eck asked about the statement that the insurance company demands the information but the insurance commissioner does not require it. Carl Bodek said he has requested a ruling from the insurance commissioner, but he has been told that he does not have to submit complete office notes to the insurance company, but only the notes necessary to process the claim.

Chairman Eck asked Tom Hopgood to respond. Mr. Hopgood said that when an insurance company is reviewing information, they ought to get information "relevant to the payment of the claim."

Chairman Eck asked Mr. Hopgood if the amendment suggested which was done for the chiropractic bill would address this question. Mr. Hopgood said under general utilization review, upon a redetermination of a claim, an individual trained in that field would do the review.

Chairman Eck asked Mr. Hopgood if the therapists or counselors refused to submit their notes, and on the basis of this there was a denial, then would there be call for a redetermination. Mr. Hopgood said there may be a misunderstanding of this.

Chairman Eck asked Mr. Hopgood what happened when a counselor or therapist refused to submit notes. Mr. Hopgood said when they refuse to submit personal notes, than the determination must be made whether this is relevant to the payment of the claim. If they did not submit the notes, he assumes the insurance company would not make a decision, and the claim could conceivably be denied.

Sen. Christiaens asked Mr. Hopgood who determined what information was "reasonably necessary" in the review of a case. Mr. Hopgood said it is difficult to define, but there is a certain degree of common sense in the insurance industry and the mental health industry.

Sen. Christiaens said what he meant was that there was protection already there regarding those decisions.

Sen. Rye asked Dr. Kohlstaedt about physical ailments being equally embarrassing, but insurance companies must know about them. Dr. Kohlstaedt said there are things that are so private, they are not at all like a physical ailment. She said that the issue is not confidentiality, but anonymity.

Dr. John Platt said in the case of mental diagnosis, there is a degree of personal information, but the case record may be filled with much more personal information, for example, family history.

Closing by Sponsor:

Sen. Doherty said Tom Hopgood's suggestion concerning the chiropractors was a good one to incorporate into SB 291. The issue of peer review should be discussed, as should utilization review.

EXECUTIVE ACTION ON SB 285

Discussion:

Susan Fox, Legislative Council, provided a memorandum regarding the Montana Hospital Association Amendments from David Niss who drafted SB 285. (Exhibit #5) Ms. Fox also provided copies of the Montana Hospital Association's amendments, (Exhibit #6), and went over them.

Chairman Eck said the suggestion was that, at the bottom of Page 2, (anti-trust) be left as a study for the Authority.

Ms. Fox said "anti-trust" is briefly addressed, but the Committee could further define it.

Sen. Christiaens said the amendments are complicated.

Sen. Franklin said Martin Burke, the chair of the committee on health care did come from Missoula. There are some amendments that could be addressed by the Committee today.

Martin Burke said that he and Clyde Dailey had a list of changes the supporters of SB 267 would suggest to SB 285.

Clyde Dailey passed out a copy of SB 285 with the suggested amendments from Sen. Bill Yellowtail's bill, SB 267. Clyde Dailey went over the amendments, which appear in smaller type. (Exhibit #7)

Sen. Eck asked Mr. Dailey and Mr. Burke to address the major issues to be addressed by the amendments.

Mr. Burke said SB 267 contains a general statement about health care policy. In defining a single-payor plan, SB 267 identifies a range of criteria which must be addressed. Mr. Burke said most of the criteria should be addressed whether there is a single-payor plan or a regulated multi-payor plan. Therefore, he proposed that items in SB 267 relating to single-payor issues which are not in SB 285 be added. Mr. Burke said both plans ought to contain a broad range of provisions, so they will expand the definitions in SB 285. In SB 267, the responsibilities of the regional planning boards are detailed to a greater extent than the responsibilities of the regional planning boards under SB 285. Mr. Burke said it was fine to expand details of boards' responsibilities. These changes are "indeed friendly amendments," because they provide greater and helpful detail.

Mr. Dailey said that was the intent. The issue of "cost containment" was not addressed because compromise already existed.

Mr. Burke said there are some disagreements, such as supporters of SB 267 would like board members to be full-time state employees. Mr. Burke said that his committee opted not to pay board members.

Mr. Dailey said they wanted paid full-time board members because they had concerns that ex-officio might "dominate" a volunteer board.

Mr. Burke said regarding the state health care resource management plan there is disagreement. In SB 267, there is an inventory of items, information, which must be addressed. Mr. Burke said that in developing a health care resource management plan, the Authority will have to look at different types of information.

Chairman Eck asked if the items in the resource management plan in SB 267 were listed in the database information system. Mr. Burke said that didn't make a difference. The information data provisions are the same in SB 267 and SB 285. There is an inventory of items to be addressed by the Health Care Authority in the development of the resource management plan, and that is consistent.

Mr. Dailey said the inventory gives the Authority direction.

Chairman Eck asked about the issue of prescription drugs as a

health care item. Mr. Burke said they agree with Sen. Yellowtail, that under the cost-containment provisions there ought to be specific mention of pharmaceuticals. The language in SB 285 was broad enough to cover pharmaceuticals, but they agree that there should be no doubt. SB 267 also asks for a study of pricing of drugs; if the date were pushed back from November 1994 to 1996, then they would agree on that issue. Mr. Burke said there was strong agreement concerning cost containment, and global budgeting.

Mr. Dailey agreed.

Sen. Klampe asked Mr. Burke and Mr. Dailey if they could walk through the bill with the Committee.

Susan Fox asked if Mr. Burke and Mr. Dailey had considered the Insurance Commissioner's amendments. Mr. Dailey said they had not been addressed.

Chairman Eck provided the Committee with a list of comparisons of insurance reform legislation. (Exhibit #8) Chairman Eck said the Committee would not address this issue at this hearing.

Mr. Burke said they could go through the amendments provided by Mr. Dailey. (Exhibit #7)

Mr. Burke said on page 3, the small print, regarding the "statement of health care policy", they do not disagree with this statement. On page 5, in the small print, there is disagreement concerning the representation of consumer groups. But the Committee could say that there should be at least one person representing consumer groups on the Authority.

Mr. Dailey said there should be mandated consumer representation on the Health Authority.

Chairman Eck asked if this would be true for whatever legislation the Committee chooses. Mr. Dailey said that was true. He had concerns that providers could dominate the process.

Mr. Burke said the committee he chaired discussed at length who should be on the Authority, and they opted not to define the members, but to leave it to the majority leaders of the House and the Senate.

Chairman Eck said that during Executive Action, this would be one of the first issues addressed by the Committee.

Mr. Burke referred to page 7, in the small print, the language regarding "executive director" and the authority of the board to hire consultants. They are in agreement, except for the language referencing "quasi-judicial" powers. They opted to eliminate this term, and Clyde Daily agreed to that.

Mr. Dailey said the point to be made is that the Board is not delegating its authority rather that doing it itself.

Chairman Eck asked about the authority of the Board to make decisions if it is not "quasi-judicial." Mr. Burke said the intention was not to cut the authority of the Board.

Mr. Dailey said later in SB 285, it is stated that the Board has subpoena powers, and that is why he is not uncomfortable with striking "quasi-judicial."

Mr. Burke said on Page 8, there is language about making the Board members full-time employees, which he would not choose to include. Mr. Burke said Pages 9, 10, 11, and 12 are all taken from SB 267, and there are provisions which address a single-payor system. Here, they suggest a list of requirements for a single-payor and a multi-payor, because the requirements will be, for the most part, the same.

Chairman Eck asked Mr. Burke if he wanted one general section of requirements, and then anything that is specifically applicable. Mr. Burke said that in SB 285 it states that there shall be a single-payor model and a multi-payor model and "the following requirements shall apply to both." This can be expanded.

Chairman Eck asked Mr. Burke if there were adequate definitions for both single-payor and multi-payor. Mr. Dailey said they did not attempt to define a regulated multi-payor system.

Chairman Eck suggested that they look at Sen. Nathe's bill because it has a couple of good definitions.

Mr. Burke said by "regulated multi-payor," they are only suggesting that any private payors are subject to a range of requirements which are delineating in SB 285.

Mr. Dailey said it would be broad and general, but it was necessary to include those requirements.

Mr. Burke said on Page 13, the indented language was an effort to spell out "expenditure targets," they agree to add the specific language. Mr. Dailey said they agreed on this issue.

Mr. Burke said SB 267 provides for the possibility of health care bargaining groups, and he does not disagree with that because it is one more mechanism for containing cost. Mr. Burke said he has no problems with health care bargaining groups, and the Authority assisting in those groups.

Sen. Christiaens asked if Mr. Burke were talking about preferred provider groups. Mr. Burke said he had not thought of it as preferred provider arrangements. He said he has no problem with the Health Care Authority assisting in discussions among two hospitals, for example, but he would go no further. There are

"big traps" with preferred provider arrangements.

Sen. Christiaens said there are about five different bills which address preferred provider organizations. There is also a bill which addresses a "willing provider," and he has concerns that there be consistency.

Mr. Dailey said on Page 18, Section 9 there is a definition of "health care provider bargaining groups." They are happy to amend this language if the Committee finds it necessary to do.

Sen. Christiaens said this is an area that needs to be looked at closely.

Mr. Burke agreed with Sen. Christiaens and said that he emphasizes the term "may" instead of the term "shall" in that section. On Page 15 and 16, there is language from SB 267 which details the factors which must be considered when creating a health care resource management plan statement. SB 267 defines a range of factors which must be identified. Mr. Burke said he agrees with this because it is a practical matter.

Mr. Dailey said the reason this language is included is that Montanans for Universal Health Care put a lot of effort into what should be included, and they feel it is comprehensive.

Chairman Eck said the decision before the Committee is how much detail to be included in the bill.

Mr. Dailey said that language addresses the use of out of state facilities by Montana residents, which they felt was important.

Mr. Burke said he agreed that the state Health Care Authority must consider the regional health care resource management plans, but it doesn't necessarily have to adopt those plans recommended by the regional panels.

Mr. Dailey said that on Page 16, "Medicaid" and "Medicare" was added under (ii) because President Clinton may give states flexibility concerning Medicaid and Medicare.

Mr. Burke said the language on Page 17 simplifies billing and claims. On Page 18, health care bargaining groups are addressed. Pages 19, 20, and 21 address anti-trust provisions from SB 267. Because they envisioned the Health Care Authority developing the plans and returning to the legislature with legislation for a single and a multi-payor plan, they saw no reason to go into detail concerning "anti-trust." Rather, SB 285 charges the Authority with developing the necessary anti-trust plan which would part of either a single-payor or a multi-payor plan. SB 267 provides anti-trust legislation immediately, and this is a "judgment call" the Committee will have to make.

Mr. Dailey said their attitude was "the more we can do now, the

less will have to be done in two years," and that is why SB 267 has anti-trust language.

Mr. Burke said he agrees with Mr. Dailey, and they have no problem with anti-trust legislation going into effect immediately. Page 23 established the health care planning regions, and all of that language is taken directly from SB 267. Sen. Yellowtail's bill would define the health care regions by county, and SB 285 states that the health care regions shall be based primarily on referral patterns. The notion of defining the regions is fine.

Sen. Franklin said there is a set of amendments from the Health Department, and the argument for getting the regions defined in the bill is so that the Authority doesn't spend too much time defining the regions.

Chairman Eck said they were very standard regions which are used throughout state government.

Sen. Christiaens said they were the same as the mental health regions.

Mr. Dailey said they were changed a little bit, because the eastern region with 17 counties was too large. Also, there is language in the bill to allow a county to petition out of one region and into another.

Mr. Dailey said the whole Page 24 should be removed.

Mr. Burke asked the Committee to look at SB 285 and the establishment of the regional boards. Pages 25 and 26 provide more detail to the creation of the regional boards, and he agrees with this language. The next set of small type, Section 16, addresses health insurance insurer cost management plans and is intended to encourage the insurance industry to participate in the overall planning process by coming forward with a cost management plan. Mr. Burke said he wasn't sure how this would work.

Mr. Dailey said the idea behind it was that the insurance companies must address the issue of cost containment over the next two years.

Mr. Burke said the final section is definitional.

Chairman Eck said there was still a request from the Department of Health that the bill specify that the state have just one health database system, and they have language they would like included.

Mr. Burke said he had no problem with this.

Chairman Eck said that the particular issue is that they have

finished the first planning phase of a Robert Wood Johnson grant, and they have the next one to turn in in May, and they need the assurance that there will be a unified system.

Mr. Burke said they were finished with the overview, and that he was satisfied with the result for a workable compromise. They favor small group insurance reform as a first step.

Chairman Eck asked Susan Fox and Tom Gomez if they could break this down into manageable amendments for the next Committee meeting.

Tom Gomez, Legislative Council, recommended that there be a substitute bill, by striking everything after the enacting clause, so that there is a clean, easy to understand text. Changes won't be seen, but it would be difficult to precede through this otherwise.

Susan Fox, Legislative Council, said before this is done, there needs to be agreement about which amendments should be included and which should not. Ms. Fox said she has five sets of amendments so far.

Chairman Eck said that when the Committee meets again, preliminary action must be taken.

Sen. Christiaens asked Ms. Fox if she had the amendments regarding anti-trust language. Ms. Fox said she did not have specific amendments.

John Flink, Montana Hospital Association, said they would get their attorney to draft the amendments to give to Ms. Fox.

Chairman Eck said the Committee would have to decide if they are going to adopt those amendments. Also, these amendments could be left to the House. Chairman Eck said the Committee may have to meet on adjournment on Thursday, February 18. She said all amendments from this hearing would be faxed to Sen. Towe.

ADJOURNMENT

Adjournment: Chairman Eck adjourned the hearing.

SENATOR DOROTHY ECK, Chair

LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-15-93

NAME	PRESENT	ABSENT	EXCUSED
Eck	✓		
Franklin	✓		
Klampe	✓		
Hager	✓		
Towe			✓
Mesaros	✓		
Rye	✓		
Christiaens	✓		

FC8

Attach to each day's minutes

MONTANA PSYCHOLOGICAL ASSOCIATION, INCORPORATED

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 2-15-93
BILL NO. SB 291

February 15, 1993

Senate Public Health Committee
Montana State Senate
Helena, Montana

Re: Senate Bill 291, An Act Revising Utilization Review Provisions; and Amending Section 33-32-201, MCA.

Madame Chairman and Members of the Committee:

With the ever-increasing need for cost control in health care, requests for information by third party payers such as health insurance companies, health maintenance organizations and their agents, have become a regular part of the health professionals daily functioning. In the mental health field, in particular, disturbing trends have become evident whereby sensitive information is requested without evidence of real need by the company performing utilization reviews, without provision of appropriately trained personnel to evaluate diagnostic and treatment decisions and without appropriate safeguards for confidential information.

It has become commonplace for providers of mental health services to receive blanket requests for all clinical records. My own and others' experience has been that a phone call to the insurer often reveals that the question which triggered the review is quite limited in scope, such as a question as to the date the patient was first seen, or as to the specific type of service that was provided on a given date. Such questions clearly do not justify a request for the entire clinical record, and we often are left with the impression that insurers are on "fishing expeditions" for other kinds of information that might be used to deny a claim.

There are instances when an insurer may legitimately question the appropriateness of a diagnosis or the necessity of a service which has been submitted for reimbursement. As an organization dedicated to human welfare, the Montana Psychological Association supports legitimate efforts to assure that patients receive appropriate, necessary, high quality services. However, we frequently find such reviews being conducted by individuals whose qualifications to address the issues are suspect: registered and licensed practical nurses, for example.

Finally, as professionals who subscribe to ethical principles which include strict rules of confidentiality, we have become deeply concerned about the potential adverse impact of utilization reviews on the privacy to which our patients are entitled. Policy-holders typically are required to agree in advance to

release information to the insurance companies or their agents. However, we feel that disclosures should be limited to what is sufficient to answer a specific question and that systems need to be in place which will better protect sensitive personal information.

Mental health professionals are well aware of the distress many patients experience when they learn of the extent of disclosure that insurance companies frequently require. I personally know of cases in which individuals have denied themselves or their children needed services or declined to submit legitimate insurance claims due to their concern about the possibilities of such disclosures. This legislation would make it possible for us to alleviate many of these concerns without compromising quality of care or cost controls.

We anticipate resistance from insurance interest groups, but believe that, upon examination, their objections will prove spurious.

One objection of which we are already aware concerns the projected cost of enacting these provisions. It may be argued that companies will incur greater costs by hiring or contracting with more highly trained personnel to conduct reviews. However, it should be pointed out that the majority of reviews will still involve questions around dates of service and specific services provided that would fall within the purview of less highly trained personnel. Companies would simply be prevented from requesting extensive case information in such instances.

In Montana, Blue Cross Blue Shield already employs a psychiatrist to review higher order questions around diagnosis and treatment decisions. Our bill would simply require that the information provided not contain names and other references which would personally identify the patient; a case number could be used instead, for identification services. The actual information solicited for such reviews would be kept in a separate file with access limited to professional level personnel as described. Determinations made by the reviewing professional could be transmitted to other personnel or file locations without revealing personal details upon which the determination was based. This is not asking a great deal.

As regards the protection of confidential information, representatives of Blue Cross Blue Shield will probably argue that new legal requirements aren't necessary because their company already has adequate safeguards in place. Our experience would suggest otherwise, in that requests by Blue Cross Blue Shield for entire files are often signed by a non-professional person. But even if

we accept Blue Cross Blue Shield's assurances, the fact remains that there are many health insurance companies operating in Montana, along with various managed care companies which conduct reviews. Consumers and providers need legal protection that sets out minimal standards that must be met.

Common sense alone supports the view that anyone charged with reviewing diagnostic and treatment decisions should also be qualified to make those kinds of clinical judgments. It is obvious that an insurance company which employs a registered nurse to conduct such reviews might have to pay more to have them performed by a more qualified individual. However, we believe that the resulting improvement in quality of care, appropriateness of feedback to the provider and reduction of expense on the part of the provider will more than offset such cost increases. The massive outlays in paperwork and professional time that ensue when unnecessary and incompetent reviews are undertaken translate into higher costs for providers and ultimately higher costs for consumers and insurance companies, in the form of higher fees to meet overhead expenses.

Over the past year, Montana Psychological Association (MPA) has communicated verbally and in writing with Blue Cross Blue Shield about how to best improve the quality of utilization reviews. At one time, a representative of Blue Cross Blue Shield's provider relations department even suggested that MPA nominate a qualified individual to be hired by Blue Cross Blue Shield to conduct such reviews. Instead, we made a counter-proposal that Blue Cross Blue Shield contract with a pool of providers to render reviews in areas of treatment or diagnosis that matched their own areas of specialization. We declined to be involved in the selection process, but did provide Blue Cross Blue Shield with a list of criteria recommended by the American Psychological Association for qualifying individuals to conduct reviews. Now, many months after this counter-proposal was sent, Blue Cross Blue Shield has still not responded.

More recently representatives of the Montana Mental Health Providers Coalition have met on several occasions with representatives of Blue Cross Blue Shield, as well as with individuals within the State Auditor's Office, to develop a fair and cost effective method of addressing our concerns. Many changes in our original proposal were made in efforts to deal with concerns raised by Blue Cross Blue Shield representatives. We realize that differences still remain, but ask the Committee to recognize the effort that has gone into the creation of a bill that is fair and feasible.

2-15-93
SB-291

In closing, we would argue strongly that utilization review should achieve not only cost reduction, but also quality assurance. The provisions of Senate Bill 291 are designed to allow for cost containment, while minimizing inappropriate interference with professional clinical judgement and unwarranted intrusions on patient privacy.

Thank you for your consideration of this proposal.

John A. Platt, Ph.D.
President, Montana Psychological Association
121 West Kagy Boulevard
Bozeman, Montana 59715
Phone: 587-7468

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2-15-93
BILL NO. SB 291

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE

PIN# GRP#

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8.88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I or any employee who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and/or 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55, No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-7, ESA-10, ESA-11, ESA-12, as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is a request for federal or federally funded payment. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

NASW MONTANA STATE CHAPTER
National Association of Social Workers 555 Fuller Avenue Helena, MT 59601 (406) 449-6208

Testimony
In Favor of Passage of Senate Bill 291:
A BILL FOR AN ACT ENTITLED: "AN ACT REVISING UTILIZATION REVIEW PROVISIONS; AND AMENDING SECTION 33-32-201, MCA"

February 15, 1993

To the Chair and Members of the Committee:

My name is Elizabeth Dane, I am the Executive Director of the Montana Chapter of the National Association of Social Workers, representing a membership of over 350 professional social workers. As part of the Montana Mental Health Providers Coalition, our Association wants to clearly state our support for SB 291.

We recognize that one of the primary purposes of utilization review is cost effectiveness in the delivery of health and mental health services. As tax paying citizens, consumers as well as social work providers of services, we find ourselves analyzing the implications of the revisions proposed in this bill from all three perspectives.

I would like to highlight our social work perspective.
We consider outpatient mental health services to be important as preventive interventions, stabilizing and supporting people in extreme psychological distress and making it possible for them to function as breadwinners, parents, family members and contributing members of the community. The availability of outpatient services reaffirms that help is there for persons in need of help. And reaffirms that they belong in the community not in inpatient or residential facilities. As such, outpatient services in themselves are a cost saving approach toward the provision of mental health care.

Members of the three professional associations who have joined together to form the Montana Mental Health Providers Coalition, represent the majority of the mental health providers throughout the state of Montana. They work in inpatient and outpatient facilities and in independent practice in all of Montana's local communities. They serve people from all walks of life: corporate leaders, shopkeepers, presidents of local banks, school teachers, car dealers, college professors. Any one of us, may at any time be vulnerable through the pressure of life's vicissitudes to the need for mental health services.

Testimony of Elizabeth Dane, D.S.W
Executive Director, NASW-MT,
555 Fuller Ave. Helena, MT 59601
(449-6208)

The Bill before you focuses on revisions in three areas of utilization review that we as social workers feel are critical for all Montana's residents.

1. An appropriate and fair professional utilization review conducted by peers.

We support the specific statement in the proposed revision that sets standards for who may conduct utilization reviews. The training that members of the four mental health professions (social workers, professional counselors, psychologists and psychiatrists, have undergone, has both significant differences, and underlying commonalties.

While it would be optimum that a utilization review be performed by a professional of the same discipline and training, this is not always logistically or economically feasible. That the review be conducted by a licensed member of one of these mental health professions provides a basic level of professional competence and relevant graduate level training that we feel is required to fairly consider the "appropriateness of diagnoses", "treatment plans", or "length of treatment".

The costs of mental health services, like other health services, presents difficult choices. All of us,providers and consumers and citizens are grappling with this issue locally and nationally.

We are certain that the changes proposed: setting limits on who may conduct utilization reviews of outpatient mental health services will contribute toward more appropriate and fairer decisions regarding reimbursement for services provided. There will be fewer inappropriate and contested denials. Efficiency will be increased, as less staff time and paperwork will be necessary. Timeliness of response aids the person needing help in getting necessary services, and will make it possible for providers of outpatient mental health services to meet community needs.

2. Setting limits on what information may be requested in the utilization review of mental health treatment.

Briefly I want to just state that we support that only the information relevant to the payment of the claim be requested. There is no need for extraneous material to be in the file of any individual who has requested reimbursement for outpatient mental health services. The more material that is available to the

Testimony of Elizabeth Dane, D.S.W
Executive Director, NASW-MT,
555 Fuller Ave. Helena, MT 59601
(449-6208)

organization, the more likelihood there is that the confidentiality an anonymity of clients and their families will be at risk.

3. Confidentiality of identifying information to insure anonymity of the patient or client.

As I mentioned before, but feel I should stress again, any one of us may be in a position to receive mental health services. As a relative newcomer to Montana from a fairly large urban center, I have been amazed at how quickly one's professional and personal visibility become blended. We see and relate to each other in a variety of roles in smaller and larger towns. We depend on one another in both professional and personal capacities. This requires that clear individual personal and professional judgment is used to insure anonymity and confidentiality. Essentially we are talking about voluntary restraints.

However in the case of organizations and institutions, we cannot leave the guidelines to maintain confidentiality and anonymity of clients and patients up to individual, voluntary judgment. There are too many individuals who may have hands on involvement with claims for outpatient mental health services within the utilization review process. Formal guidelines with the force of legislative requirement must be in place.

If there is the suspicion that their private mental health problems will become common community knowledge, individuals needing help for mental problems will be more likely to wait until these problems are creating a major interference with work and family responsibilities, before they seek out a mental health professional. This will increase the likelihood that they will need more long term outpatient mental health services, or the most costly alternative of all, inpatient hospitalization.

In sum the three proposed revisions in SB 291 have the potential to provide the optimum response to supporting clients in getting to outpatient mental health services when they need them, without fear of inappropriate denials,misuse of information and breaches of confidentiality

Representing the National Association of Social Workers,I urge you to support SB 291.

Thank you for the opportunity to share our concerns with you.

We would be pleased to answer any questions you may have.

SENATE HEALTH & WELFARE
EXHIBIT NO 4
DATE 2-15-93
BILL NO. SB 291

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MARC RACICOT
GOVERNOR

PETER S. BLOUKE, PhD
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210

TESTIMONY OF THE DEPARTMENT OF SOCIAL
AND REHABILITATIVE SERVICES BEFORE THE
SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
(RE: SB 291 REVISE UTILIZATION REVIEW OF
OUTPATIENT MENTAL HEALTH TREATMENT NOTES)
FEBRUARY 15,1993

INTRODUCED COPY

Senate Bill 291 revises the utilization review process that can be used to perform medical necessity review of outpatient mental health treatment.

SRS is interested in this bill because of its potential impact on utilization review of Medicaid services. SRS supports the concept of utilization review being done by qualified medical or health professionals. We also understand and support the need to keep all medical review confidential. Our concern with this bill lies with how these things will be accomplished.

Section 1 (1) specifies that only social workers, psychologists, licensed professional counsellors, and psychiatrists can perform medical necessity review of outpatient mental health services. It further specifies that only psychologists can deny benefits for a psychological evaluation. This severely limits Medicaid's ability to perform review with state staff or contract with utilization review firms. In our past experience with these UR firms, the majority of them employ psychiatric nurses to perform review. The state also employs nurses to do this type of review. These restrictive requirements will result in increased costs to the state and severely hamper our ability to perform review.

The existing state statute (MCA 33-32-102 (1)) already specifies that adverse determinations can only be made by a "health care professional trained in the relevant area of health care". SRS believes that this language is restrictive enough to ensure that review is done by appropriate medical professionals, yet it does not add unnecessary specifications as to which professionals must perform which kind of review.

If the committee does not agree with striking this section in its entirety, we would ask that section 1 (1) be amended to include psychiatric nurses and physicians after licensed psychiatrist on line 17. We would also request that the language on page 1, lines 17 through 20, beginning with "except that a utilization review for

denial of benefits for psychological evaluations must be performed by a licensed psychologist." be eliminated.

SRS interprets section 1 (3) to mean that medical records must have all names removed before they can be reviewed for medical necessity. This is a very time consuming and costly process. A patient's medical record, in some instances, may be several hundred pages. Concealing the identity of individuals would necessitate copying the record, then sitting down with a crayon or bottle of white out and removing every mention of the client's name from the record. This process can only add to the already high cost of providing health care services.

Confidentiality is already required in order to comply with the provisions of MCA 33-22-204 (3). If there is some problem that we are unaware of with confidentiality, SRS would propose that a fine or penalty be specified for breaching confidentiality. We would ask that the present section 1 (3) be deleted in its entirety or replaced with language that specifies that a penalty may be imposed if confidentiality is not kept.

Thank you for this opportunity to present our concerns.

Submitted by : 

Peter Blouke, PhD.
Director
Department of SRS

med/legtes93.291

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 2-15-93
BILL NO. SB 285

MEMORANDUM

TO : Susan Fox

FROM: David Niss

RE : Amendments Proposed to SB 285 by the Montana Hospital Association

DATE: February 13, 1993

Several days ago you asked for my assistance in reviewing the amendment proposed by the Montana Hospital Association to SB 285. This memorandum constitutes the results of my review.

The amendments proposed by the Association that I reviewed would: (1) delete a mandatory requirement that the Montana health care authority include in its universal access plans proposed legislation allowing providers and consumers to negotiate agreements, and make the inclusion of that legislation discretionary with the Authority; and (2) insert 6 new sections of law requiring the issuance of certificates of public advantage to health care providers apparently authorizing those providers to enter into what might otherwise be classified as anticompetative agreements with other health care providers. The proposal by the Association also provides for revocations of the certificates and an appeal process.

It is unclear from the Association's proposal how the authority's proposed legislation, which under the Association's proposal is allowed rather than mandated to be proposed by the Authority as part of the access plans, would supplement or coordinate with the Association's proposed amendments.

The importance of Section 8, subsection (3) of SB 285 (page 12, line 20 through page 13, line 7) is to give the authority ample opportunity and reason to conduct a study to determine the effect of federal and state laws governing anticompetative business arrangements on the health care industry. The effect of these laws has been considered so substantial by other states enacting health care reform measures that some of those states, such as Minnesota, have enacted statutes exempting under certain conditions agreements such as those contemplated by the Hospital Association from the effect of those state and federal antitrust laws (see, Ch.549, sec.14, Minn. Laws 1992). The effect of exemptions such as that enacted by Minnesota is to bring otherwise anticompetative agreements within the scope of what is called the "state action" immunity from the Sherman Antitrust Act, 15 U.S.C. sec. 1, et sec.

The theory of "state action" immunity from the Sherman Act is a judicially created immunity first announced by the United States Supreme Court in Parker v. Brown, 317 U.S. 41 (1943), and later clarified in California Retail Liquor Dealers Association v. Midcal Aluminum, Inc., 445 U.S. 97 (1980). In Midcal, the Court found that a state regulatory scheme could be the basis for antitrust immunity if that scheme satisfied a two-part test. First, the scheme had to be founded upon a state policy "clearly articulated and affirmatively expressed" allowing anticompetative conduct. Second, that state had to provide for active supervision of the anticompetative conduct allowed by the state policy. Midcal, 445 U.S., at 105. Thus, in order for agreements between health care providers in Montana to be immune from Sherman Act enforcement, the state regulatory scheme must satisfy the two pronged test of Midcal.

It's clear from a reading of the amendment submitted by the Hospital Association that the Association's proposal alone does not satisfy the Midcal test. Thus, if no other legislation were enacted to implement a "state action" immunity scheme other than the amendment proposed by the Association, health care providers agreeing with other health care providers to fix the prices of health care services would be found in violation of the Sherman Antitrust Act. This is because the proposed amendment contains no clearly expressed state policy allowing the contemplated anticompetative conduct, and may not provide sufficient guarantees of active state supervision of the price fixing agreements except through the rules authorized but not required by section 17, subsection (3) of the proposed amendment. You may wish to compare the language of the Association's proposal with SB 267, section 26, which in my judgment much more clearly satisfies the Midcal test.

The issue that the Association's proposed amendment presents to the Senate Public Health Committee is whether to (1) adopt the Association's proposed amendment, hoping that legislation recommended by the health care authority in the plans to be presented to the legislature on October 1, 1994 will contain the other details of a state regulatory scheme satisfying the Midcal "state action" immunity requirements, (2) reject the amendment and hope that one complete scheme is presented in those plans, or (3) amend the Hospital Association's proposal sufficiently to be sure it satisfies the Midcal requirements, and then adopt the proposal.

My recommendation is that the Committee not adopt the Association's proposal, and that the study and recommendations of the health care authority be left to address this issue. The reasons for this recommendation are: (1) there is no necessity to adopt any regulatory scheme offering "state action" immunity at this point in time, given the structure of SB 285, as other pieces of the universal access puzzle will not fall into place until the 54th Legislature acts on the authority's plans; (2)

adoption of the Association's proposal at this time would to some degree preempt the work of the health care authority, which may decide there is either no necessity at all for "state action" immunity in Montana given the other features of the plans to be presented to the legislature, or that a state regulatory "state action" immunity scheme must be structured much differently than the Association proposes, and (3) there is no provision in the Association's proposal for agreements between providers and consumers, authorizing what has been called in other states health insurance purchasing cooperatives (HIPCs) or health insurance networks, under which agreements between providers and consumers would receive the benefits of "state action" immunity. Such a scheme, again, should be the province of the authority's study and legislation now mandated by section 8 of SB 285 to be included in the authority's report to the legislature.

If you have any questions concerning the foregoing, please advise me.

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 2-15-93
BILL NO. SB 285

PROPOSED AMENDMENTS TO SB 285

Proposed by the Montana Hospital Association

1. Title, line 18.

Following: "VITAL STATISTICS;"

Insert: "ALLOWING HEALTH CARE FACILITIES TO ENTER INTO COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF THE AUTHORITY;"

2. Page 3, line 9.

Following: "cost-effective."

Insert: [new paragraph] "A statement of intent is also required because [sections 14 through 16] permit the authority to adopt rules relating the issuance and revocation of a certificate of public advantage for a cooperative agreement. The authority's rules must comport with the legislature's intent to provide the state, through the authority, direct supervision and control over applicant health care facilities, and it is the intent that this state direction, supervision, and control will provide state action immunity to groups of health care facilities that have a valid certificate of authorization under [Sections 13 through 18] in the event that such cooperative actions otherwise could be construed as in conflict with federal or state antitrust laws.

3. Page 5, line 3.

Following: "the authority."

Insert: "The attorney general is a non-voting, ex officio member of the authority solely for the purposes of studying and making recommendations concerning the impacts of state and federal antitrust laws on health care services in the state pursuant to [section 3] and approving and supervising cooperative agreements pursuant to [sections 13 through 18]."

4. Page 12, line 24.

Following: "authority"
Strike: "shall"
Insert: "may"
Following: "plans"
Insert: "additional"

5. Page 20.

Following: line 19
Insert: "NEW SECTION. **Section 13.** "Cooperative agreement defined. (1) "Cooperative Agreement" means a written agreement among two or more health care facilities for the sharing, allocation or referral of patients, personnel, instructional programs, emergency medical services, support services and facilities or medical, diagnostic or laboratory facilities or procedures or other services customarily offered by health care facilities.

"NEW SECTION. **Section 14.** Certification for cooperative agreement. 1. A health care facility may negotiate and enter into a cooperative agreement with one or more other health care facilities in the state if the authority determines the cooperative agreement is likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

2. (a) Parties to a cooperative agreement may apply to the authority for a certificate of public advantage governing the cooperative agreement. The application must include a copy of the executed cooperative agreement and a description of the nature and scope of the cooperation contemplated by the cooperative agreement, including any consideration passing to any person under the terms of the cooperative agreement.

(b) The authority may adopt rules including but not limited to rules for the form and content of applications for a certificate of public advantage.

3. Within 90 days after receipt of a complete application for a certificate of public advantage, the authority shall grant or deny the application. When considered appropriate by the department, the authority may hold a public hearing within such 90 day period.

"NEW SECTION. **Section 15.** Reconsideration and appeal. (1) Applicants for a certificate of public advantage may request the authority to reconsider its decision. The authority shall grant the request if an applicant submits the request in writing and if the request is received by the authority within 30 calendar days after the initial decision is announced.

(2) A public hearing to reconsider must be held within 30 calendar days after the request is received unless the applicants agree to waive the time limit.

(3) The reconsideration hearing must be conducted pursuant to the provisions for informal proceedings of the Montana Administrative Procedure Act.

(4) The authority shall make its final decision and serve the applicants with written findings of fact and conclusions of law in support of the decision within 30 days after the conclusion of the reconsideration hearing.

(5) The applicants may appeal the authority's final decision to the district court as provided in Title 2, chapter 4, part 7.

(6) The department may by rule prescribe in greater detail the hearing and appellate procedures.

"NEW SECTION. **Section 16.** Standards for certification. The authority shall issue a certificate of public advantage for a cooperative agreement if it determines the applicants have demonstrated that the agreement is likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

"NEW SECTION. **Section 17.** Revocations of certificate of public advantage.(1) The authority may revoke a certificate of public advantage if it determines that the agreement is not resulting in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

(2) A certificate of public advantage may not be revoked without notice and an opportunity for hearing before the authority given as follows:

(a) Written notice shall be given the parties to the cooperative agreement for which the certificate of public advantage is proposed to be revoked not less than 120 days prior to the proposed revocation.

(b) If a party to the cooperative agreement submits a request for hearing in writing and the request is received by the authority within 30 calendar days after notice is mailed to the parties, the authority shall hold a public hearing to determine whether the certificate of public advantage should be revoked.

(c) A public hearing to determine whether the certificate of public advantage should be revoked must be held within 30 calendar days after the request is received.

(d) The hearing must be conducted pursuant to the provisions for informal proceedings of the Montana Administrative Procedure Act.

(e) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of the decision within 30 days after the conclusion of the reconsideration hearing.

Exhibit #6
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(f) Any party to the cooperative agreement may appeal the authority's final decision to the district court as provided in Title 2, chapter 5, part 7. No revocation of a certificate of public advantage may become final until the time for appeal to the district court has expired.

(g) If a petition to appeal the revocation of a certificate of public advantage is filed, the revocation must be stayed pending resolution of the appeal by the courts.

(h) The authority may by rule prescribe in greater detail the hearing and appellate procedures.

(3) The authority may by rule establish reporting requirements for parties to a cooperative agreement for which a certificate of public advantage is in effect for the purpose of determining whether the agreement continues to be likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace.

"NEW SECTION. **Section 18.** Recordkeeping. The authority shall maintain on file cooperative agreements for which a certificate of public advantage is in effect. Any party to a cooperative agreement who terminates the agreement shall file written notice of the termination within 30 days after such termination.

Renumber: subsequent sections.

6. Page 22.

Following: "[Section 13(1) through (9)]"
Delete: "is"
Insert: "and [Sections 13 through 18] are"

BILL NO. 285

INTRODODUCED BY

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL HEALTH CARE ACCESS, HEALTH CARE PLANNING AND COST CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY; PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY; REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN; REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING; REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH PLANNING REGIONS AND BOARDS; PROVIDING FOR THE POWERS AND DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR HEALTH INSURANCE REFORM; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES RELATING TO VITAL STATISTICS; AMENDING SECTION 50-15-101, MCA; AND PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of legislative intent is required for this bill because [section 13] requires the Montana health care authority to adopt rules establishing a maximum of five

SENATE HEALTH & WELFARE
EXHIBIT NO. 7
DATE 2-15-93
BILL NO. SB 285

health care planning regions, to establish regional health care planning boards within those regions, and to establish a procedure for selection of regional board members. ~~The legislature intends that the rules establishing the health care planning regions be based primarily upon the geographic health care referral patterns by which health care providers refer patients to specialists or larger health care facilities. These rules should also consider communication and transportation patterns and~~ natural barriers ~~to these patterns~~. The rules establishing the boards must specify the number of members, any relevant qualifications, and the operations and duties of the boards and must provide for a funding mechanism by grant from the authority. The procedure for selection of the board members must provide for public notice of the selection process.

A statement of intent is also required because [section 15] requires the authority to adopt rules relating to the unified health care data base. The authority's rules must specify in comprehensive detail what information is required to be provided by health care providers and the times at which the information is to be provided. The rules must also provide for audit procedures to determine the accuracy of the filed data. The confidentiality provisions must be consistent with other state laws governing the confidentiality of public records, including medical

SB285
INTRODUCED BILL

records, and must apply to employees of the authority and to others receiving or using records in the data base.

A statement of intent is also required because [section 17] requires the commissioner of insurance to adopt rules governing small employer group health plans. In determining the basic benefits package, the commissioner shall make objective determinations, supported by available data, concerning the type of benefits required and shall determine that the benefits to be required are cost-effective.

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

NEW SECTION. **Section 1.** State health care policy. (1) It is the policy of the state of Montana to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary to develop a health care system that is integrated and subject to the direction and oversight of a single state agency. Comprehensive health planning through the application of a statewide health resource management plan that is linked to a unified health care budget for Montana is essential.

(2) It is further the policy of the state of Montana that the health care system should:

(a) maintain and improve the quality of health care services offered to Montanans;

(b) contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income or the money available for other services required to ensure the health, safety, and welfare of Montanans;

(c) avoid unnecessary duplication in the development and offering of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(e) promote rational allocation of health care resources in the state; and

(f) facilitate universal access to preventive and medically necessary health care.

of [sections 2 through 13], the following definitions apply:

(1) "Authority" means the Montana health care authority created by [section 1].

(2) "Board" means one of the regional health care planning boards created pursuant to [section 10].

(3) "Data base" means the unified health care data base created pursuant to [section 12].

(4) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

(5) "Health insurer" means any health insurance company, 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.

(6) "Health care provider" or "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.

(7) "Management plan" means the health care resource management plan required by [section 6].

(8) "Region" means one of the health care planning regions created pursuant to [section 10].

(9) "Statewide plan" means one of the statewide universal health care access plans for access to health care required by [section 4].

NEW SECTION. Section 3. Montana health care authority -- allocation -- ~~membership~~. (1) There is a Montana health care authority.

(2) The authority is allocated to the department of health and environmental sciences for administrative purposes as provided in 2-15-121.

(3) The authority consists of five voting members. Each member must be knowledgeable in different aspects of health care. Three members must be health care consumers or represent consumer organizations.

(a) Within 30 days of [the effective date of this section], the majority and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment

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to the authority.

(b) Within 30 days of [the effective date of this section], the majority and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(c) Within 90 days of [the effective date of this section], the governor shall appoint from those nominated under subsections (3)(a) and (3)(b) five individuals to the authority.

(4) A vacancy must be filled in the same manner as original appointments under subsection (3), except that one individual must be selected under subsection (3)(a) and one under subsection (3)(b). The governor shall appoint from those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and rehabilitation services and the department of health and environmental sciences are nonvoting, ex-officio members of the authority.

NEW SECTION. Section 4 Administration of health car authority -- reports -- compensation. (1) The authorit shall employ a full-time executive director who shal conduct or direct the daily operation of the authority. Th executive director is exempt from the application o 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 throug 2-18-1013 and serves at the pleasure of the authority.

The executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the board.

(2) The board may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. The board may not delegate its quasi-judicial and rulemaking powers and may not delegate its authority to adopt the state health resource management plan, the unified health care budget, budgets for the authority and board, or budgets for the regional panels.

(3) The board may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The board may:

(a) apply for and accept gifts, grants, or contributions from any person for purposes consistent with [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37];

(b) adopt rules necessary to implement [sections 1, 2, and 5 through 30]; and

(c) enter into contracts and perform other acts necessary to accomplish the purposes of [sections 1, 2, and 5 through 30].

(5) The authority shall report to the legislature and the governor at least twice a year on its progress since the last report in fulfilling the requirements of [sections 2 through 13]. Reports may be provided in a manner similar to 5-11-210 or in another manner determined by the authority.

(6) All the board members must be full-time state employees, exempt from Title 2, chapter 18, parts 1 and 2. The annual salary of the presiding officer is 85% of the annual salary of the presiding officer of the public service commission. The annual salary of each of the other members is 85% of the annual salary of public service commissioners other than the presiding officer.

(7) The authority shall make grants to the boards for the operation of the boards. The authority shall provide for uniform procedures for grant applications and budgets of the boards.

NEW SECTION. **Section 5.** Statewide universal health care access plans required. On or before October 1, 1994, the authority shall submit a report to the legislature that contains the authority's recommendation for a statewide universal health care access plan based on a single payor concept and a recommendation for a statewide universal access plan based on a regulated multiple payor concept. Each statewide plan must guarantee access to health care services for residents of Montana by making available a uniform system of health care benefits. Each statewide plan must contain the features required by this section and [sections 5 through 8].

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. (2) On or before November 1, 1994, the board shall submit a report to the legislature containing the board's recommendations, including any necessary legislation, for a universal access plan based on the concept of a single payor. The plan must contain recommendations that if implemented, would provide universally accessible, medically necessary, and preventive health care by October 1, 1995.

(3) For the purposes of this section, "single payor system" means a method of financing health services predominantly through public funds so that all residents of Montana would have available to them a uniform set of benefits established by statute or administrative rule. Policies governing all aspects of the management of the single payor system reside with state government, and benefits would be administered by a single entity. The single payor system must include:

(a) universal coverage for all Montana residents;

(b) a single governmental or nongovernmental administrative entity that makes payments through contracts with health care providers;

(c) portability of coverage regardless of job status;

(d) uniform benefits from a single source for all Montana residents;

(e) a broad-based public financing mechanism, including revenues from employers, employees, public sources, or any combination of the listed sources;

(f) a system capped for provider expenditures;

(g) global budgeting for hospitals;

(h) controlled capital expenditures;

(i) a binding cap on overall expenditures; and

(j) policymaking for the system as a whole and accountability within state government.

(4) The single payor system must provide for the use of the state health resource management plan, the unified health care budget, , the certificate of need process, and other health care cost containment mechanisms. The single payor system must include

the following features:

(a) an integrated system or systems of health care delivery;

(b) incentives to be used to contain costs and direct resources;

(c) uniform benefits to be made available, including nutrition benefits, prenatal benefits, and maternity care;

(d) reimbursement mechanisms for health care providers;

(e) administrative efficiencies;

(f) the appropriate use of midlevel practitioners, such as physicians' assistants and nurse practitioners;

(g) mechanisms for applying and implementing the unified health care budget on a statewide basis to all sectors of the health care system;

(h) mechanisms for reducing the cost of prescription drugs, both as part of and as separate from the uniform benefit plan;

(i) appropriate reallocation of existing health care resources;

(j) equitable financing of the proposal;

(k) requirements for the payment of premiums or copayments by health care consumers, based upon family size and ability to pay;

(l) a waiting period of a total of 3 months prior to receipt of benefits for a person who has been a resident of

Montana for less than that period of time; and

(4) integration, to the extent possible under federal and state law, of benefits provided under the single payor system with the benefits provided by the United States department of veterans affairs and benefits provided by the Indian health service.

(5) The single payor system must also include a mechanism for the authority to provide health care in those areas of Montana near the borders where it would be more practicable for health care consumers to seek care from metropolitan areas in neighboring states. If the authority determines that contracts with out-of-state providers are required to provide this mechanism and that it lacks sufficient authority to contract with those providers, the authority shall in its report propose legislation necessary for the exercise of those powers.

(6) In its report, the authority shall present, at a minimum, the range of services that would be available under the universal access plan if there were no increase, beyond inflation, in the total gross health care expenditures in Montana, as determined by the authority from the health care data base established under [section 12] for the first year that an expenditure figure is available.

(7) In developing the universal access plan, the authority shall examine the effect of government regulation

and economic incentives on the overall operation of the health care system and, specifically, on how those parts of the universal access plan recommended pursuant to subsections (2) through (5) may most appropriately be used in furthering the policies and goals of [sections 1, 2, and 5 through 30]; 50-1-201; Title 50, chapter 5, parts 3 and 4; Title 90, chapter 7; and [section 37].

(3) **Hearings on universal access plan.** The board shall seek public comment on the development of the universal access plan. In seeking public comment on the development of the board's recommendations for the universal access plan, the board shall provide extensive, multimedia notice to the public and hold at least one public hearing in each of the health care planning regions established by [section 27]. To the extent possible, the board shall arrange for hearings to be broadcast on interactive television. The hearings must take place before the board's report is submitted to the legislature. The board shall consult with health care providers in the development of the board's recommendations for the universal access plan.

process. (9) The board shall conduct a study of the certificate of need process established under Title 50, chapter 5, part 3. The study must determine whether changes in the certificate of need process are necessary or desirable in light of the board's recommendation for a single payor health care system required by [section 17]. The study must include consideration of the role, effect, and desirability of:

(a) maintaining the exemptions from the certificate of need process for offices of private physicians, dentists, and other physical and mental health care professionals; and

(b) maintaining the dollar thresholds for health care services, equipment, and buildings and for construction of health care facilities.

(2) The results of the study, including any recommendations for legislation and changes in an agency's policies or rules, must be reported to the legislature no later than December 1, 1994.

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NEW SECTION. **Section 6.** Cost containment. (1) The statewide plans must contain a cost containment component. Except as otherwise provided in this section, each statewide plan must establish a target for cost containment so that by 1999, the annual average percentage increase in statewide health care costs does not exceed the average annual percentage increase in the gross domestic product, as determined by the U.S. department of commerce, for the 5 preceding years.

(2) The health care expenditure target may include sectors or subsectors for health care facilities, health care providers, or any other part of the health care system that the board determines is necessary. The board shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the expenditure target. Prior to adopting the expenditure target, the board shall adopt:

(a) the methods and processes to be used to allocate resources among sectors; and

(b) the economic indicators to be used to define the parameters of the rate of growth in the cost of the system and the various sectors of the system.

(3) The authority shall include the following features in the cost containment component:

(a) global budgeting for all health care spending;

(b) a system for limiting demand of health care services and controlling unnecessary and inappropriate health care. The system may include prioritization of services that allows for consideration of an individual patient's prognosis.

(c) a system for reimbursing health care providers for services and health care items. The reimbursement system must provide that all payors, public or private, pay the

same rate for the same health care services and items and that reimbursement for services is based predominantly upon the health care service provided rather than upon the discipline of the health care provider.

(d) a method of monitoring compliance with the target required in subsection (1);

(e) expenditure targets for health care providers and facilities;

(f) disincentives for exceeding the targets established pursuant to subsection (3)(e), including reduction of reimbursement levels in subsequent years;

(g) reimbursement of health care providers and health care facilities that is based upon negotiated annual budgets or fees for services; and

(h) a plan by the authority, health care providers, and health care facilities to educate the public concerning the purpose and content of the statewide plans.

(8) The board shall enter into discussions or nonbinding negotiations with health care facilities and any health care provider bargaining groups created under [section 11] concerning matters related to the sectors of the unified health care budget.

NEW SECTION. Section 7. Health care resource management plan. (1) Each statewide plan must contain a health care resource management plan. The management plan must provide for the distribution of health care resources within the regions established pursuant to [section 10] and within the state as a whole, consistent with the principles provided in subsection (2).

(2) The state plan must include:

(a) a statement of principles used in the allocation of resources and in establishing priorities for health services;

(b) identification of the current supply and distribution of:

(i) hospital, nursing home, and other inpatient services;

(ii) home health and mental health services;

(iii) treatment services for alcohol and drug abuse;

(iv) emergency care;

(v) ambulatory care services, including primary care resources;

(vi) nutrition benefits, prenatal benefits, and maternity care;

(vii) human resources;

(viii) major medical equipment; and

(ix) health screening and early intervention services;

(c) a determination of the appropriate supply and distribution of the resources and services identified in subsection (2)(b) and of the mechanisms that will encourage the appropriate integration of these services on a local or regional basis. To arrive at a determination, the authority shall consider the following factors:

(i) the needs of the statewide population, with special consideration given to the development of health care services in underserved areas of the state;

(ii) the needs of particular geographic areas of the state;

(iii) the use of Montana facilities by out-of-state residents;

(iv) the use of out-of-state facilities by Montana residents;

(v) the needs of populations with special health care needs;

(vi) the desirability of providing high-quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; and

(vii) the cost impact of these resource requirements on health care expenditures.

(d) a component that addresses health promotion and disease prevention and that is prepared by the department of health and environmental sciences in a format established by the authority; and

(i) include incentives to improve access to and use of preventive care; primary care services, including mental health services; and community-based care;

(ii) include incentives for healthy lifestyles; and

(e) a component that addresses integration of the plan, to the extent allowed by state and federal law, with services provided by the Indian health service and by the United States department of veterans affairs, and by the Medicaid and Medicare Program

(3) The state plan must be based upon the regional health resource plans prepared by regional panels in accordance with [section 30]. The board shall adopt rules to ensure that regional health resource plans are developed in a consistent manner.

(4) The state plan must be revised annually in a manner determined by the board.

(5) Prior to adoption of the state plan, the board shall hold one or more public hearings for the purpose of receiving oral and written comment on a draft plan. After hearings have been concluded, the board shall adopt the state plan, taking comments into consideration.

(5) include incentives to improve access to health care in underserved areas, including:

(a) a system by which the authority may identify persons with an interest in becoming health care professionals and provide or assist in providing health care education for those persons; and

(b) tax credits and other financial incentives to attract and retain health care professionals in underserved areas;

NEW SECTION. **Section 8.** Health care billing **simplification.** (1) Each statewide plan must contain a component providing for simplification and reduction of the

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costs associated with health care billing. In designing this component, the authority may consider:

(a) conversion from paper health care claims to standardized electronic billing;

(b) creating a claims clearinghouse, consisting of a state agency or private entity, to receive claims from all health care providers for compiling, editing, and submitting the claims to payors; and

(c) By January 1, 1994, the commissioner of insurance, after consultation with the board, shall adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of electronic claim forms.

(2) The health care billing component must include a method to educate and assist health care providers and payors who will use any health care billing simplification system recommended by the authority.

(3) The billing component must provide a schedule for a phase-in of any health care billing simplification system recommended by the authority. The schedule must relieve health care providers, payors, and consumers of undue burdens in using the system.

NEW SECTION. Section 7. Health care provider bargaining groups. (1) The board may approve the creation of one or more health care provider bargaining groups, consisting of health care providers who choose to participate. On behalf of all of its member providers, a bargaining group is authorized to negotiate:

(a) with the authority with respect to any matter authorized by [section 8] related to sectors of the unified health care budget and with respect to any matter related to reimbursement of health care providers; and

(b) with the Montana health care purchasing pool, with respect to any matter authorized by [section 8] and to any matter related to reimbursement of health care providers.

(2) The board shall adopt by rule:

(a) criteria for forming and approving bargaining groups; and

(b) criteria and procedures for negotiations authorized by this section.

(3) The rules relating to negotiations pertaining to sectors of the unified health care budget must include provisions for a nonbinding arbitration process to assist in the resolution of disputes. This section or rules adopted under this section may not be construed to limit the board's authority to reject the recommendation or decision of the arbiter or limit the board's authority under [section 8] to establish the unified budget.

(4) Contracts for reimbursement of health care providers negotiated under this section must be consistent with the unified health care budget and the state health resource management plan and may not take effect unless approved by the board.

(5) One or more health care providers may jointly comment on rules proposed by the board and discuss any other matters related to negotiations between the authority and health care providers.

(6) The negotiations authorized by this section are limited to the right to discuss the matters identified in subsection (1) and may not be construed to authorize a bargaining group to engage in any other type of activity. The board shall adopt rules to implement this subsection.

NEW SECTION. Section 10. Other matters to be included in statewide plans. (1) The statewide plans recommended by the authority must include:

(a) stable financing methods, including sharing of the costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phasein of the various components of the plans.

(2) On or before December 15, 1994, and December 15, 1996, the board shall report to the legislature on ~~the~~ operation of the purchasing pool, including the number and types of groups and group members participating in the pool, the costs of administering the pool, the savings attributable to participating groups from the operation of the pool, and any changes in legislation considered necessary by the board.

(3) On or before December 15, 1996, the board shall report to the legislature with its recommendations concerning the feasibility and merits of authorizing the board to act as an insurer in pooling risks and providing benefits, including a common benefits plan, to participants of the purchasing pool.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

(i) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

(ii) propose any changes, including legislation, that it considers necessary, including measures for compensating victims of tortious injuries.

(b) As part of its study, the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be included in its report containing the statewide plans.

(3) The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by some cooperative arrangements involving health care providers or purchasers that would be prohibited by state and federal antitrust laws

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if undertaken without governmental involvement. The purpose of this section is to create an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result either in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. The legislature intends that approval of relationships be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power.

(2) The authority shall establish criteria and procedures to review and authorize contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that might be construed to be violations of state or federal antitrust laws but that are in the best interests of the state and further the policies and goals of [sections 1, 2, and 5 through 30]. The authority may not approve any application unless the authority finds that the proposed arrangement is likely to result in lower health care costs or in greater access to or quality of health care than would occur in the competitive marketplace. The authority may condition approval of a proposed arrangement on a modification of all or part of the arrangement to eliminate any restriction on competition that is not reasonably related to the goals of

controlling costs or improving access or quality. The authority may also establish conditions for approval that are reasonably necessary to protect against any abuses of private economic power and to ensure that the arrangement is appropriately supervised and regulated by the state. The authority shall actively monitor and regulate arrangements approved under this section to ensure that the arrangements remain in compliance with the conditions of approval. The authority may revoke an approval upon a finding that the arrangement is not in substantial compliance with the terms of the application or the conditions of approval.

(3) (a) Applications for approval under this section must be filed with the authority. An application for approval must describe the proposed arrangement in detail. The application must include:

(i) the identities of all parties;

(ii) the intent of the arrangement;

(iii) the expected effects of the arrangement;

(iv) an explanation of how the arrangement will control costs or improve access or quality; and

(v) financial statements showing how the efficiencies of operation will be passed along to patients and purchasers of health care.

(b) The authority may ask the attorney general to comment on an application, but the application and any information obtained by the authority under this section are not admissible in any proceeding brought by the attorney general based on antitrust.

(5) Notwithstanding the state statutes concerning unfair trade practices, any contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that are approved by the authority under this section do not constitute an unlawful contract, combination, or conspiracy in unreasonable restraint of trade or commerce or unfair trade practices under Title 30, chapter 14. Approval by the authority is an absolute defense against any action under state antitrust or unfair trade practices laws.

(7) The authority shall adopt rules to implement this section.

(3) The authority shall apply for waivers from federal laws necessary to implement recommendations of the authority enacted by the legislature and to implement those recommendations not requiring legislation.

NEW SECTION. Section 11 Study of prescription drug cost and distribution. The authority shall conduct a study of the cost and distribution of prescription drugs in this state. The study must consider the feasibility of various methods of reducing the cost of purchasing and distributing prescription drugs to Montana residents. The study must include the feasibility of establishing a prescription drug purchasing pool for distribution of drugs through pharmacists in this state. The results of the study, including the board's recommendations for any necessary legislation, must be reported to the legislature by December 1, 1994. If the board determines that feasible methods are available without need for legislation or further appropriations, the board shall implement that part or those parts of its recommendations.

NEW SECTION. Section 12 Long-term care study and recommendations. The authority shall conduct a study of the long-term care needs of state residents and report to the public and the legislature the authority's recommendations, including any necessary legislation, for meeting those long-term care needs. The report must be available to the public on or before September 1, 1996, after which the authority shall conduct public hearings on its report in each region established under [section 10]. The authority shall present its report to the legislature on or before January 1, 1997.

(2) This section does not preclude the authority from recommending cost-sharing arrangements for long-term care services or from recommending that the services be phased in over time. The board's recommendations must support and may not supplant informal care giving by family and friends and must include cost containment recommendations for any long-term care service suggested for inclusion.

(3) The board's report must estimate costs associated with each of the long-term care services recommended and may suggest independent financing mechanisms for those services. The report must also set forth the projected cost to Montana and its citizens over the next 20 years if there were no change in the present accessibility, affordability, or financing of long-term care services in this state.

(4) The board shall consult with the department of social and rehabilitation services in developing its recommendations under this section.

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NEW SECTION. Section 13. Health care planning regions. (1) There are five health care planning regions. Subject to subsection 2, the regions consists of the following counties:

(a) Region I: Daniels, Sheridan, Roosevelt, McCone, Richland, Dawson, Wibaux, Prairie, Custer, Fallon, Powder River, and Carter;

(b) Region II: Glaicier, Tool, Liberty, Hill, Blaine, Pondera, Chouteau, Teton, Cascade, Judith Basin, and Fergus;

(c) Region III: Phillips,Valley, Garfield, Rosebud, Treasurer, Petroleum, Musselshell, Golden Valley, Stillwater, Yellowstone, Big Horn, and Carbon;

(d) Region IV: Wheatland, Sweetgrass, Park, Meagher, Broadwater, Gallatin, Madison, Beaverhead, Silver Bow, Deer Lodge, Jefferson, and Lewis and Clark;

(e) Region V: Powell, Granite, Ravalli, Missoula, Mineral, Sanders, Lake, Flathead, and Lincoln;

(2) (a) A county may, by written request of the board of county commissioners, petition the authority at any time to be removed from a health care planning region and added to another region.

(b) The authority shall grant or deny the petition after a public hearing upon notice as the authority determines. The authority shall grant the petition if it appears by a preponderance of the evidence that the petitioning county's health care interests are more strongly associated with the region that the county seeks to join than with the region in which the county is then located. If the authority grants the petition, the county is considered for all purposes to be part of the health care planning region as approved by the board.

(3) Within each health care planning region created by [section 27] is a regional health care planning panel.

(4) Each regional panel consists of 11 members as provided in this section. Regional panel members must be appointed for 6-year terms, except that of the first panels appointed, three members must be appointed for a term of 2 years, three members must be appointed for a term of 4 years, and five members must be appointed for a term of 6 years.

(5) The county commission of each county within a region shall nominate five persons for membership on the regional panel. The list of nominees must be sent to the authority, which shall select from the list of nominees the members on each regional panel.

(6) Each regional panel must include:

(a) at least five members who represent health care consumers and who are not affiliated with a health care profession or health care facility;

(b) at least two representatives of health care providers;

(c) at least one representative of hospitals;

(d) at least one representative of health care facilities; and

(e) at least two representatives of private business.

(7) Each regional panel must include experts in law, economics, and other fields and must include members of the health care professions, sufficient for the panel to carry out its duties under [section 30].

(8) Within each region, the board shall establish by rule a regional health care planning board. Each board must include one member from each county within their respective regions. The members on each board must repesent a balance of individual who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care.

(9) The authority shall, within 30 days of appointment of its members, propose by rule a procedure for selecting members of boards. The authority shall select five members for each board within 180 days of appointment of the authority, using the selection procedure adopted by rule under this subsection. Vacancies on a board must be filled by using the authority's selection process.

(10) Regional board members serve 4-year terms, except that of the board members initially selected, one member serves for 2 years, two members serve for 3 years, and two members serve for 4 years, to be determined by lot. A majority of each regional board shall select a presiding officer. The presiding officer initially selected must serve a 4-year term. Board members must be compensated and reimbursed in accordance with 2-15-124.

NEW SECTION. **Section 14** Duties of boards. A board shall:

(1) meet at the time and place designated by the presiding officer, but not less than quarterly;

(2) submit an annual budget and grant application to the authority at the time and in the manner directed by the authority;

(3) adopt procedures governing its meetings and other aspects of its day-to-day operations as the board determines

(4) develop regional health resource plans that must address the health care needs of the region, address the development of health care services in underserved areas of the region and other matters, and be in the format determined by the authority;

(5) revise the regional plan annually;

(6) hold at least one public hearing on the regional plan within the region at the time and in the manner determined by the regional panel;

(7) transmit the regional plan to the authority at the time determined by the authority;

(8) apply to the authority for grant funds for operation of the regional panel and account, in the manner specified by the authority, for grant funds provided by the authority; and

(9) seek from local sources money to supplement grant funds provided by the authority.

(C) Regional boards may:

(1) recommend that the authority sanction voluntary agreements between health care providers and between health care consumers in the region that will improve the quality of, access to, or affordability of health care but that might constitute a violation of antitrust laws if undertaken without government direction;

(2) make recommendations to the authority regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by health care providers;

(3) undertake voluntary activities to educate consumers, providers, and purchasers and promote voluntary, cooperative community cost containment, access, or quality of care projects; and

(4) make recommendations to the department of health and environmental sciences or to the authority, or both, regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

(5) Each regional board may review and advise the authority on regional technical matters relating to the universal access plan required by [section 17], the common benefits package, procedures for developing and applying practice guidelines for use in the universal access plan, provider and facility contracts with the state, utilization review recommendations, expenditure targets, and uniform health care benefits and their impact upon the provision of quality health care within the region.

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NEW SECTION. **Section 17.** Health care data base -- information submitted -- enforcement. (1) The authority shall develop and maintain a unified health care data base that enables the authority, on a statewide basis, to:

(a) determine the distribution and capacity of health care resources, including health care facilities, providers, and health care services;

(b) identify health care needs and direct statewide and regional health care policy to ensure high-quality and cost-effective health care;

(c) conduct evaluations of health care procedures and health care protocols; and

(d) compare costs of various health care procedures in one location of providers and health care facilities with the costs of the same procedures in other locations of providers and health care facilities.

(2) The authority shall by rule require health care providers, health insurers, and health care facilities, private entities, and entities of state and local governments to file with the authority the reports, data, schedules, statistics and other information determined by the authority to be necessary to fulfill the purposes of the data base provided in subsection (1). Material to be filed

with the authority may include health insurance claims and enrollment information used by health insurers.

(3) The authority may issue subpoenas for the production of information required under this section and may issue subpoenas for and administer oaths to any person. Noncompliance with a subpoena issued by the authority is, upon application by the authority, punishable by a district court as contempt pursuant to Title 3, chapter 1, part 5.

(4) The data base must:

(a) use unique patient and provider identifiers and a uniform coding system identifying health care services; and

(b) reflect all health care utilization, costs, and resources in the state and the health care utilization and costs of services provided to Montana residents in another state.

(5) Information in the data base required by law to be kept confidential must be maintained in a manner that does not disclose the identity of the person to whom the information applies.

(6) The authority shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

(7) The duties of the authority under this section may not be construed to allow the authority to use the data base to manage a health care facility in a manner that usurps the appropriate powers of the board of directors of the facility.

NEW SECTION. Section 16 Health insurer cost management plans. (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the board no later than January 1, 1994.

(b) The board may use plans filed under this section in the development of the unified health care budget.

(2) The plans required by this section must be developed in accordance with standards and procedures established by the board.

(3) The provisions of this section do not apply to dental insurance.

NEW SECTION. **Section 17. Small employer group health insurance reform.** (1) As used in this section, the following definitions apply:

(a) "Health plan" or "plan" means the plan specified in the rules adopted pursuant to subsection (2).

(b) "Person" means an individual, corporation, firm, partnership, sole proprietorship, or other business entity.

(c) "Small employer" means a person employing at least 3 but not more than 25 employees.

(2) The commissioner of insurance shall adopt rules specifying the health care benefits to be included in health care plans offered by small employers.

(3) A health insurer who offers a health plan to a small employer in Montana shall offer the same health plan to other small employers in Montana and shall allow continuous open enrollment in that plan.

(4) A health insurer who offers a health plan may not limit preexisting conditions for a period longer than 6 months after the effective date of coverage under the plan.

(5) A health insurer may not cancel, refuse to issue, or refuse to renew coverage under a health plan for any reason other than nonpayment of premiums or fraud or

material misrepresentation by the insured in the application for coverage under the plan.

(6) A health insurer shall provide notice to an insured of the terms of renewal of coverage under a health plan at least 10 days before the expiration of the coverage. The terms upon which coverage under the plan is offered to the insured for renewal may not be any less favorable, with respect to all provisions, including benefits but excluding premium rates and minor administrative changes, than the terms of the coverage about to expire.

(7) A health insurer may not charge a higher premium for renewal of coverage under a health plan than for initial coverage under the same plan.

(8) A health insurer shall renew coverage under a health plan for not less than 12 months.

(9) A health insurer may not require an insured or a person applying for coverage under a health plan with that insurer to comply with limitations in a health plan concerning preexisting conditions if that insured or person has previously satisfied preexisting condition requirements of another health insurance policy or plan offering substantially similar benefits.

(10) Except as provided in subsection (11), all health insurers shall establish a single rating scheme that is applied consistently for health plans and does not

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discriminate between persons as to the amount of the premium based upon differences in sex, health status, employment, or geographic location.

(11) (a) The commissioner of insurance shall adopt by rule standards and a procedure to allow health insurers to use one or more risk classifications in establishing their rating system. The rating system may not contain a rate spread greater than 30% of the median rate or less than 30% of the median rate.

(b) The commissioner shall phase in the requirements of subsection (10) and this subsection as the commissioner considers appropriate.

(c) By July 1, 1995, a premium rate may not exceed 125% of the premium rate for the least expensive group.

(12) On [6 months from the effective date of this subsection] the commissioner of insurance shall adopt rules implementing this section. The rules adopted by the commissioner become effective on [1 year from the effective date of this subsection].

Section 15 Section 50-1-201, MCA, is amended to read:

"50-1-201. Administration of state health plan. The department Montana health care authority created in [section 3] is ~~hereby established as~~ the ~~sole and official~~ state agency to administer the state program for comprehensive health planning and ~~is hereby authorized to~~ shall prepare a plan for comprehensive state health planning. The department authority ~~is authorized to~~ may confer and cooperate with any ~~and all~~ other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The department authority, while acting in this capacity as the ~~sole and official~~ state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the ~~sole and official~~ state agency to accept, receive, expend, and administer any and all funds which are

or appropriated to it for the preparation, and administration, and the supervision of the preparation and administration of the comprehensive state health plan."

Section 19. Section 50-5-101, MCA, is amended to read:

"50-5-101. Definitions. As used in parts 1 through 4 of this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Accreditation" means a designation of approval.

(2) "Adult day-care center" means a facility, freestanding or connected to another health care facility, which provides adults, on an intermittent basis, with the care necessary to meet the needs of daily living.

(3) "Affected person" means an applicant for certificate of need, a member of the public who will be served by the proposal, a health care facility located in the geographic area affected by the application, an agency which establishes rates for health care facilities, a third-party ~~payer~~ payor who reimburses health care facilities in the area affected by the proposal, or an agency which plans or assists in planning for ~~such~~ affected facilities.

(4) "Ambulatory surgical facility" means a facility, not part of a hospital, which provides surgical treatment to patients not requiring hospitalization. This type of facility may include observation beds for patient recovery

from surgery or other treatment.

(5) "Authority" means the Montana health care authority created by [section 3].

~~(5)~~(6) "Batch" means those letters of intent to seek approval for new beds or major medical equipment that are accumulated during a single batching period.

~~(6)~~(7) "Batching period" means a period, not exceeding 1 month, established by department authority rule during which letters of intent to seek approval for new beds or major medical equipment are accumulated pending further processing of all letters of intent within the batch.

~~(7)~~(8) "Board" means the board of health and environmental sciences, provided for in 2-15-2104.

~~(8)~~(9) "Capital expenditure" means:

(a) an expenditure made by or on behalf of a health care facility that, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; or

(b) a lease, donation, or comparable arrangement that would be a capital expenditure if money or any other property of value had changed hands.

~~(9)~~(10) "Certificate of need" means a written authorization by the department authority for a person to proceed with a proposal subject to 50-5-301.

~~(10)~~(11) "Challenge period" means a period, not

exceeding 1 month, established by department authority rule during which any person may apply for comparative review with an applicant whose letter of intent has been received during the preceding batching period.

~~(11)~~(12) "Chemical dependency facility" means a facility whose function is the treatment, rehabilitation, and prevention of the use of any chemical substance, including alcohol, ~~which~~ that creates behavioral or health problems and endangers the health, interpersonal relationships, or economic function of an individual or the public health, welfare, or safety.

~~(12)~~(13) "Clinical laboratory" means a facility for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

~~(13)~~(14) "College of American pathologists" means the organization nationally recognized by that name with headquarters in Traverse City, Michigan, that surveys clinical laboratories upon their requests and accredits clinical laboratories that it finds meet its standards and requirements.

~~(14)~~(15) "Comparative review" means a joint review of

two or more certificate of need applications ~~which~~ that are determined by the ~~department~~ authority to be competitive in that the granting of a certificate of need to one of the applicants would substantially prejudice the ~~department's~~ authority's review of the other applications.

~~(15)~~ (16) "Construction" means the physical erection of a health care facility and any stage ~~thereof~~ of erection, including ground breaking, or remodeling, replacement, or renovation of an existing health care facility.

~~(16)~~ (17) "Department" means the department of health and environmental sciences provided for in Title 2, chapter 15, part 21.

~~(17)~~ (18) "Federal acts" means federal statutes for the construction of health care facilities.

~~(18)~~ (19) "Governmental unit" means the state, a state agency, a county, municipality, or political subdivision of the state, or an agency of a political subdivision.

~~(19)~~ (20) "Health care facility" or "facility" means any institution, building, or agency or portion ~~thereof~~ of any agency, private or public, excluding federal facilities, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. The term does not include offices of private physicians or dentists. The term includes but is not limited

to ambulatory surgical facilities, surgical centers, health maintenance organizations, home health agencies, hospices, hospitals, infirmaries, kidney treatment centers, long-term care facilities, medical ~~assistance~~ facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatment facilities, and adult day-care centers.

~~(20)~~(21) "Health maintenance organization" means a public or private organization ~~which~~ that provides or arranges for health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or group of providers.

~~(21)~~(22) "Home health agency" means a public agency or private organization or subdivision ~~thereof--which~~ of an agency or organization that is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

~~(22)~~(23) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and ~~his~~ the patient's family arising out of physical, psychological, spiritual, social, and

economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component.

~~(23)~~(24) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick persons. Services provided may or may not include obstetrical care, emergency care, or any other service as allowed by state licensing authority. A hospital has an organized medical staff which that is on call and available within 20 minutes, 24 hours per day, 7 days per week, and provides 24-hour nursing care by licensed registered nurses. This term includes hospitals specializing in providing health services for psychiatric, mentally retarded, and tubercular patients.

~~(24)~~(25) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmary--A" provides outpatient and inpatient care;

(b) an "infirmary--B" provides outpatient care only.

~~(25)~~(26) "Joint commission on accreditation of hospitals" means the organization nationally recognized by that name with headquarters in Chicago, Illinois, that

surveys health care facilities upon their requests and grants accreditation status to any health care facility that it finds meets its standards and requirements.

~~(26)~~(27) "Kidney treatment center" means a facility ~~which~~ that specializes in treatment of kidney diseases, including freestanding hemodialysis units.

~~(27)~~(28) (a) "Long-term care facility" means a facility or part ~~thereof--which~~ of a facility that provides skilled nursing care, intermediate nursing care, or intermediate developmental disability care to a total of two or more persons or personal care to more than four persons who are not related to the owner or administrator by blood or marriage. The term does not include adult foster care licensed under 52-3-303, community homes for the developmentally disabled licensed under 53-20-305, community homes for persons with severe disabilities licensed under 52-4-203, youth care facilities licensed under 41-3-1142, hotels, motels, boardinghouses, roominghouses, or similar accommodations providing for transients, students, or persons not requiring institutional health care, or juvenile and adult correctional facilities operating under the authority of the department of corrections and human services.

(b) "Skilled nursing care" means the provision of nursing care services, health-related services, and social

services under the supervision of a licensed registered nurse on a 24-hour basis.

(c) "Intermediate nursing care" means the provision of nursing care services, health-related services, and social services under the supervision of a licensed nurse to patients not requiring 24-hour nursing care.

(d) "Intermediate developmental disability care" means the provision of nursing care services, health-related services, and social services for the developmentally disabled, as defined in 53-20-102(4), or persons with related problems.

(e) "Personal care" means the provision of services and care ~~which~~ that do not require nursing skills to residents needing some assistance in performing the activities of daily living.

~~(28)~~(29) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions ~~which~~ that is used to provide medical or other health services and costs a substantial sum of money.

~~(29)~~(30) "Medical assistance facility" means a facility that:

(a) provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours; and

(b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital.

~~(30)~~ (31) "Mental health center" means a facility providing services for the prevention or diagnosis of mental illness, the care and treatment of mentally ill patients or the rehabilitation of ~~such~~ mentally ill persons, or any combination of these services.

~~(31)~~ (32) "Nonprofit health care facility" means a health care facility owned or operated by one or more nonprofit corporations or associations.

~~(32)~~ (33) "Observation bed" means a bed occupied for not more than 6 hours by a patient recovering from surgery or other treatment.

~~(33)~~ (34) "Offer" means the holding out by a health care facility that it can provide specific health services.

~~(34)~~ (35) "Outpatient facility" means a facility, located in or apart from a hospital, providing, under the direction of a licensed physician, either diagnosis or treatment, or both, to ambulatory patients in need of medical, surgical, or mental care. An outpatient facility may have observation beds.

~~(35)~~ (36) "Patient" means an individual obtaining services, including skilled nursing care, from a health care facility.

~~(36)~~(37) "Person" means any individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

~~(37)~~(38) "Public health center" means a publicly owned facility providing health services, including laboratories, clinics, and administrative offices.

~~(38)~~(39) "Rehabilitation facility" means a facility ~~which~~ that is operated for the primary purpose of assisting in the rehabilitation of disabled persons by providing comprehensive medical evaluations and services, psychological and social services, or vocational evaluation and training or any combination of these services and in which the major portion of the services is furnished within the facility.

~~(39)~~(40) "Resident" means a person who is in a long-term care facility for intermediate or personal care.

~~(40)~~(41) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility to psychiatrically impaired individuals with persistent patterns of emotional, psychological, or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remedy the individual's condition. Residential psychiatric care must be individualized and designed to achieve the patient's

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discharge to less restrictive levels of care at the earliest possible time.

~~(41)~~(42) "Residential treatment facility" means a facility operated for the primary purpose of providing residential psychiatric care to persons under 21 years of age.

~~(42)~~(43) "State health plan" means the plan prepared by the department authority to project the need for health care facilities within Montana ~~and--approved--by--the--statewide health-coordinating-council-and-the-governor.~~"

NEW SECTION. Section 10. Effective dates. (1) [Sections 1 through 12, 13(10) through (12), 14, 15, and this section] are effective on passage and approval.

(2) [Section 13(1) through (9)] is effective [1 year from the date of passage and approval of this act].

NEW SECTION. Section 11. Codification instruction. (1) [Section 1] is intended to be codified as an integral part of Title 2, chapter 15, and the provisions of Title 2, chapter 15, apply to [section 1].

(2) [Sections 2 through 13] are intended to be codified as an integral part of Title 50, and the provisions of Title 50 apply to [sections 2 through 13].

-End-

SENATE HEALTH & WELFARE
EXHIBIT NO. 8
DATE 2-15-93
BILL NO. SB 285

COMPARISON OF SPECIFIC PROVISIONS OF INSURANCE REFORM LEGISLATION

	CURRENT STATUTE	HOUSE BILL 508	SENATE BILL 285 (Current)	O'KEEFE AMENDMENTS	SEN CHRISTIAENS' BILLS
Availability	No provisions.	Guaranteed issue	Insurers must offer plan to other small employers and must allow "continuous open enrollment."	Guaranteed issue	Guaranteed issue
Group Size	No provisions.	3 - 25	3 - 25	3 - 25	All individual and group policies, regardless of size.
Whole Groups	No provisions.	Cannot exclude eligible employees based on health status or claims experience.	No specific provision.	Cannot exclude eligible employees based on health status or claims experience.	"Coverage" to every individual.
Applicability		Applies to any policy marketed through a small employer and for which the employer pays a portion of the premium or claims federal tax deductions.	No specific provision.	Applies to any policy marketed through a small employer and for which the employer pays a portion of the premium or claims federal tax deductions.	All individual and group policies, regardless of size.
Renewability	Renewal at insurers' discretion after notice.	Guaranteed renewable except "for cause." Carriers exiting the market barred from re-entry for 5 years.	Guaranteed renewable except "for cause." Must renew for at least 12 months.	Guaranteed renewable except "for cause." Carriers exiting the market barred from re-entry for 5 years.	Guaranteed renewable except "for cause." Carriers exiting the market barred from re-entry for 5 years.
Premium Rate Restrictions	No provisions.	Index rate for one class of business may not exceed index rate for any other class by more than 20%. Within a class of business, rates may not vary from the index rate by more than 30%. Once cost containment goal in SB285 is met, within class rates may not vary by more than 20%. Rating disclosure required.	Rates may not vary by more than 30% from the median rate. By July 1995, a rate may not exceed 125% of the least expensive group.	Index rate for one class of business may not exceed index rate for any other class by more than 20%. Within a class of business, rates may not vary from the index rate by more than 25%. Once cost containment goal in SB285 is met, within class rates may not vary by more than 20%. Rating disclosure required.	No variation in premium rate permitted.
Case Characteristics	No provisions in insurance code.	Demographic and other objective characterisitics as regulated by commissioner. Claims experience, health status and duration of coverage not considered case characteristics.	Determined by commissioner.	Demographic and other objective characterisitics as regulated by commissioner. Claims experience, health status and duration of coverage not considered case characteristics.	None allowed.

	CURRENT STATUTE	HOUSE BILL 508	SENATE BILL 285 (Current)	O'KEEFE AMENDMENTS	SEN CHRISTIAENS' BILLS
Transitional Period		Three years	None.	Three years	None allowed.
Renewal Rates		Trend plus 15% plus changes in case characterisitics. Rate variations due to health status or claims experience applied uniformly within and across groups.	No higher than for initial coverage.	Trend plus 15% plus changes in case characterisitics. Rate variations due to health status or claims experience applied uniformly within and across groups.	No specific provision.
"Portability" or Continuity	Preexsiting condition exclusion limited to 12 months.	Preexisting condition exclusion limited to 12 months. Credit given for qualifying previous coverage if continuous for 1 year up to no more than 30 days prior to submission for new coverage. Late enrollees subject to 18 months. Individual riders prohibited.	Preexisting condition exclusions limited to 6 months. Preexisting condition exclusion prohibited if previously satisfied in plan offering substantially similar benefits.	Preexisting condition exclusion limited to 12 months. Credit given for qualifying previous coverage if continuous for 1 year up to no more than 30 days prior to submission for new coverage. No difference for late enrollees. Individual riders prohibited.	Preexisting condition exclusion limited to 12 months. Credit given for qualifying previous coverage if continuous for 3 months up to no more than 6 months prior to new coverage. Late enrollees not included.
Risk Sharing Mechanism	Montana Comprehensive Health Association plan available to medically uninsurable.	Prospective reinsurance with broad based funding for net losses.	No specific provision.	Prospective reinsurance, no specified funding for net losses.	No specific provision.
Reinsurnace Price		For whole groups: 150% of base reinsurnace premium rate. For individuals: 500% of base reinsurance premium rate.	No specific provision.	For whole groups: 150% of base reinsurnace premium rate. For individuals: 500% of base reinsurance premium rate.	No specific provision.
Carrier Liability		For each employee or dependent $5000 plus 20% of next $50,000 for maximum exposure per insured of $15,000.	No specific provision.	For each employee or dependent $5000 plus 20% of next $100,000 for maximum exposure per insured of $15,000.	No specific provision.
Consumer Protection Measures		Standards of fair market conduct. Periodic market evaluation.	No specific provision.	Standards of fair market conduct. Periodic market evaluation.	No specific provision.
Other		Basic and standard benefit plans to be determined by committee appointed by commissioner. State mandated benefits and freedom of choice of practitioner waived.	Commissioner to determine benefits to include in policy.	Basic and standard benefit plans to be determined by committee appointed by commissioner. Freedom of choice of practitioner waived.	

DATE 2-15-93

SENATE COMMITTEE ON Public Health

BILLS BEING HEARD TODAY: SB 291 Doherty

Name (please Print)	Representing	Bill No.	Check One Support	Oppose
Elizabeth Dane	National Assoc. of Social Workers	291	✓	
Kathy McGowan	[illegible]		✓	
Joan A. Flatt	Montana Psychological Assn	291	✓	
Elizabeth Kohlstadt Ph.D	Clinical Psychology	291	✓	
Tom Hopgood	Health Ins. Assoc. America	291		✓
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS	291		✓
Mary Dalton	SRS - Medicaid	291		
Mary McCue	Mt Clinical Mental Health Counselors Assn	291	✓	
Carl Bodek	" "	291	✓	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10

NAME CARL BOUEK

ADDRESS 210 N. HIGGINS MSLA

HOME PHONE _____ WORK PHONE 721-6183

REPRESENTING SELF- MCMHCA

APPEARING ON WHICH PROPOSAL? SB 291

DO YOU: SUPPORT X OPPOSE _____ AMEND _____

COMMENTS:

WITNESS STATEMENT

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY