MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Chairman Eck said that because there was not a quorum present, the Committee would meet as a Subcommittee, and votes would wait until a quorum was present.

EXECUTIVE ACTION ON SB 285

Discussion:

Chairman Eck thanked Tom Gomez, Legislative Council, for his work on SB 285. (Exhibit #1)

Mr. Gomez said there was still the issue of effective dates that needed to be addressed. In both SB 267 and SB 285 the dates were effective immediately. Mr. Gomez asked Sen. Franklin if that were still the case.

Sen. Franklin said it was.

Mr. Gomez said that he would have to add it. In Section 21, there is language relating to the transfer of state health planning to the new Health Care Authority. The effective date under SB 267 was July, 1996. The last date concerns the Small Employer Insurance Availability Act for January 1, 1994.

Sen. Franklin said that was correct.

Tom Gomez said SB 285 states on Page 8, Section 5, that by October 1, 1994, the Authority will prepare a universal health care access plan.

Chairman Eck said the Committee should consider the amendments about whether the Authority would be made up of volunteers or full-time paid employees. There was never an amendment submitted, but she asked Sen. Rye to submit all the amendments to SB 285.

Sen. Rye said he had two sets of amendments.

Chairman Eck said there were amendments from the Montana Medical Association, and there would be amendments relating to insurance.

Melissa Case said she had amendments that were not in amendment form.

Chairman Eck said there were also amendments from the Montana Hospital Association relating to anti-trust. There were also

amendments from the Department of Health. Chairman Eck asked Ms. Case to address her amendments.

Ms. Case said there would be a new definition of "case characteristics" which would read, "case characteristics means age of an individual..."

Chairman Eck asked Ms. Case to explain why this definition would be preferable to what is in the bill currently. Ms. Case said SB 285 states that a person can be placed in a case characteristic based on demographic characteristics. Her amendments states that the only reason an individual should be placed in a category is the basis of age.

Chairman Eck asked if there were anyone from the Insurance Commissioner's office who would want to address the issue of demographics. Carol Roy said age characteristics, as far as rating on an insurance policy, they do go hand in hand.

Chairman Eck if the language would make a difference. Ms. Case said "objective characteristics" is a broad term.

Ms. Roy said the Commissioner's office would be promulgating rules as the characteristics become apparent. In order to be a small employer carrier, an application must be made to the Commissioner with the objective plan. At that time, the Insurance Commissioner will know what the demographic criteria will be. Ms. Roy reminded the Committee that insurance is risk management, and demographics could mean the difference between a group of teachers and a group of loggers. There are different risk levels with different occupations.

Ms. Case said the grouping of individuals based on their occupation was unnecessary, but if all the other "objective" characteristics are removed, age is left.

Sen. Franklin asked Ms. Case what her proposal was. Ms. Roy said that all demographic or other objective characteristics would be removed and the only criteria for rating under Ms. Case's banding system would be age.

Sen. Rye said all insurance is risk assessment, and actuarial experience is what makes insurance work. Certain things are true, such as women live longer than men.

Chairman Eck said that was already taken care of.

Ms. Case said there could be no discrimination based on sex or national origin.

Sen. Rye said he had concerns with removing actuarial experience as the basis for discrimination. He said he did not agree with this concept.

Sen. Towe asked Ms. Case where "case characteristics" was used in the text of the bill. Ms. Case said it was used throughout the bill.

Sen. Towe asked Ms. Roy if the gray bill included the Insurance Commissioner's proposals. Ms. Roy said it did.

Sen. Towe asked Ms. Roy if she were representing the Insurance Commissioner. Ms. Roy said she was.

Sen. Towe asked Ms. Roy under what context "case characteristics" was used. Ms. Roy said case characteristics were used to describe the mechanism which replaces the current underwriting system, and it must be defined which case characteristics are allowable. In SB 285, this relates to how an insurer, or "carrier" can rate different groups.

Ms. Case said one concern with community rating was that the healthiest portion of the population will discontinue insurance coverage. Ms. Case said that placing individuals into rate bands according to age will stop the loss of the younger, healthy population.

Sen. Towe asked Ms. Roy what the term "demographics" meant. Ms. Roy said it would be the difference between a logger and a teacher.

Sen. Towe asked Ms. Roy if that was demographics. Ms. Roy said that occupational hazards were demographic, not objective.

Sen. Towe asked Ms. Roy about the Commissioner allowing for rate bands, and what was permissible. Ms. Roy said that Ms. Case only allows age to be the differing factor between bands. Ms. Roy said the Commissioner offers a 9-band system which fluxuates because demographic differences, such as occupational differences, are taken into consideration.

Sen. Towe asked Ms. Roy if territory would be taken into consideration. Ms. Roy said it could be because it is less expensive to receive health care in some areas than in others. There could be objective rating to cover this.

Chairman Eck asked Ms. Roy about class of business, which would cover loggers and teachers. Ms. Roy said class of business means "all or a separate grouping of small employers established" which is the line of business.

Sen. Towe asked Ms. Roy if this were considered to be occupation. Ms. Roy said it wasn't. Two different insurers would have different classes of business. Ms. Roy said the language may not be very specific, but the promulgation of rules could make it more specific. Ms. Roy directed the Committee's attention to the language in Section 26.

Sen. Towe asked Ms. Roy if there could be different classes for high-risk jobs, such as logging, and another class for low-risk jobs such as office workers. Ms. Roy said that would result in marketing problem because it is difficult to buy a block of business and incorporate it.

Chairman Eck asked Ms. Roy if a class of business were different than a band. Ms. Roy said if the Committee accepted the Insurance Commissioner's amendments, there would be nine bands. If the Committee accepted Ms. Case's amendments, there would be seven. The Commissioner's bands allow for more underwriting.

Chairman Eck asked Tanya Ask how demographics and case characteristics are used in small group policies. Ms. Ask said as it is currently written, individual case characteristics for each group are looked at, and that includes that group's individual claims experience. Groups that have higher utilization will have higher rates. The purpose of including utilization as a case characteristic is to reflect the experience of an individual group. The Commissioner's proposal would significantly narrow the rate that the insurance company could charge, or the level that would reflect group experience.

Chairman Eck asked Ms. Ask if case characteristics would then include group experience rather than occupational differences. Ms. Ask said demographic experience, such as the experience of an employment group, will be looked at.

Chairman Eck asked Ms. Ask how many bands there were currently. Ms. Ask said there were far more than nine.

Chairman Eck asked Ms. Ask about states that had adopted this type of rating system. Ms. Ask said states have continued to look at utilization of the groups, health status of the groups, age, occupation, the traditional demographics as well as different costs according to different regions.

Sen. Towe asked Ms. Ask what her thoughts were concerning case characteristics. Ms. Ask said they would like to see the Insurance Commissioner's language remain. If rating can only be based on age, there will be a greater impact on those individuals who are relatively healthy because their rates would rise even more.

Ms. Roy said there it a huge compromise for the insurance companies to limit only on the basis of age, and it would "just about ruin the business."

Sen. Towe said there was a definition contradiction between Sections 22-36, and Section 26. Ms. Case said her amendment addresses this inconsistency.

Tom Hopgood said the definitions of "case characteristics" and "class of business" are different. Mr. Hopgood said case

characteristics are underwriting factors and in simplifying underwriting if it is limited to one factor, but it is inaccurate. The more factors used to manage risk, the more effective the insurance product can be delivered to the insured.

Ms. Case said on Page 31, the definition of "late enrollee" should include "after marital separation" as well as divorce.

Sen. Towe asked why "divorce" was not adequate. Ms. Roy said that if a woman divorces her husband, he can be dropped from the insurance plan before the employer knows of the divorce. The husband may not know he's been dropped, and his time to find new coverage may expire. Ms. Roy said she agreed with this amendment.

Ms. Case said in Section 20, Page 33, "qualifying previous coverage" should include coverage of six months rather than one year. Essentially this allows individuals on disability insurance or welfare benefit plan to get off that and get coverage under a small employer, so they do not have to wait a year for coverage. This provides the means to get off public assistance.

Ms. Roy said the Commissioner's office has no authority over federally regulated plans, and it might not work from an insurer to an ERISA group.

Chairman Eck asked Ms. Roy if Medicare and Medicaid were all right. Ms. Roy said she thought so.

Chairman Eck asked Ms. Roy about disability insurance. Ms. Roy said disability includes health insurance, but the language must be made clear in the promulgation of rules. Their office has no authority over ERISA covered groups, and cannot enforce this.

Chairman Eck asked about the time period of six months. Ms. Ask said that if an individual has only a six month waiting period, it would allow someone to get coverage after they know they are pregnant, for example.

Ms. Case said that had been changed to nine months. Ms. Ask said the waiting period had been routinely one year because there are always questions concerning the exact date of pregnancy.

Ms. Case said CHAMPUS was included as well.

Sen. Towe asked Ms. Roy why there was a problem with the ERISA groups. Ms. Roy said the problem is moving from an ERISA plan to a private insured plan, but the preemption issue comes into effect when the move is from a private insured plan to an ERISA plan. The door "will only swing one way."

Sen. Towe said he didn't see any reason to exclude ERISA groups. Ms. Roy said that was fine.

Ms. Case said that "small employer carrier" should reflect different classes "only on the basis of age."

Sen. Towe asked Ms. Roy how she felt about this language. Ms. Roy said there is a problem of over-utilization, and a deterrent to this is a higher premium.

Sen. Towe asked Ms. Case how she would respond. Ms. Case said that some of the underwriting characteristics were not logical and reasonable, and were discriminatory. The only discrimination should be age.

Sen. Towe asked Ms. Roy about high rates for a group because one employee has enormous medical bills, or utilization. Ms. Roy said it could be a "shock loss" to an insurance company, and their claim experience can later be pooled out. The risk will be taken off that one insurer.

Chairman Eck asked if there were states that had established a class of business on the basis of age. Ms. Roy said that states that had done small market reform have a less-strict version of this plan.

Chairman Eck asked Ms. Case if there were states that had adopted community rating plans with no factors taken into consideration. Ms. Case said Maine had this type of plan.

Ms. Roy said Maine has adopted small group reform, but hasn't really adopted community rating that Ms. Case outlined.

Ms. Case said a definition of "pre-existing condition" would be added, which would repeal section 33-22-216 of the current code. The definition would be "an illness, disease, injury or other condition that existed within a year of the effective date of the new coverage as evidenced by medical and advised diagnosis care or treatment that was recommended or received for the condition."

Chairman Eck if this were an unusual definition. Ms. Case read the current definition of "pre-existing definition" as in the code. Ms. Case said the exclusion of the condition must be no more than twelve months.

Ms. Roy said the current code definition is the result of the compromise reached by the legislature last year.

Ms. Case said the problem with this is that people with pre-existing conditions cannot go without insurance for more than one year.

Ms. Ask said individuals will still have insurance, but they won't have coverage of the pre-existing condition. Other conditions will be covered.

Ms. Case said her language covers those who cannot afford not to

have insurance on a pre-existing condition.

Ms. Roy said it affects only those who wait until they are hurt to purchase insurance.

Chairman Eck asked about the instance of an individual denied insurance because of an alcohol treatment program as the result of a DUI. Ms. Roy said that individual would not be denied insurance, and will not have a pre-existing condition if he is continuously covered.

Ms. Case said portability coverage is continuous coverage as long as individuals enroll in the new insurance plan within 30 days.

Sen. Towe asked Ms. Case if that didn't take care of her concerns. Ms. Case said if an individual drops insurance because they cannot afford it, for example, and then tries to pick it up, there may be pre-existing conditions for up to a year. Ms. Case said they want to change the time from one year to six months.

Chairman Eck asked Ms. Case to briefly go through the amendments, and said she would not guarantee the Committee would take action on them tonight.

Ms. Case said the business rating index should not exceed 5%.

Sen. Rye asked Ms. Case the rationale behind this. Ms. Case said this was to shrink the band. The lowest charge and the highest charge within a band should not exceed 5%.

Sen. Towe asked Ms. Case if this would affect the other eight bands. Ms. Case said the numbers are changed throughout the bill to reflect this, because it does affect the other bands.

Ms. Roy said this effectively brings the lowest priced premium up.

Chairman Eck asked Ms. Case what the difference between the very lowest and the very highest would be. Ms. Case said within a band, it would be 5%, between the lowest and the highest bands it would be 35%.

Chairman Eck asked what the difference between the very lowest and the highest bands were in the proposal as written. Ms. Roy said the difference would be 185%.

Chairman Eck asked Larry Akey if he would address this. Mr. Akey drew a diagram explaining the 185% difference in rates.

Sen. Towe asked Mr. Akey what the impact of this proposal was. Mr. Akey said the reason they went for broader rate bands was a concern that insurance companies would rate from the top down, which would make other rates higher. If the bands are narrowed too much, individuals in the bottom rate bands will drop off

because their rates will rise.

Sen. Towe asked what the objective of the limits was. Mr. Akey said the objective of rate banding was to limit the abuses in rating. The purpose is to pool the risks. There must be subsidization at the bottom of the market, so the bands are artificially pulled together.

Sen. Towe asked Mr. Akey if Ms. Case's suggestion was that the bands be pulled farther together. Mr. Akey said that was correct. The Legislature must determine how far the rates bands should be pulled together. Sen. Christiaens' bill on community rating states that there are no bands, and there is no difference in rates.

Ms. Case said this is addressed in rate banding by age because then the younger, healthier individuals are not lost.

Chairman Eck asked Mr. Akey what the status of Rep. Russell Fagg's bill in the House was. Mr. Akey said that bill will be treated as an appropriation bill and will not be heard until after transmittal.

Ms. Case said on Page 37 annual adjustments of premiums should not exceed 10% rather than 15%. Ms. Roy said the problem with this language is that current medical inflation is over 10%.

Ms. Ask said that actual experience may be higher than inflation because inflation does not address unbundled services or increases in the number of reimbursable providers. Ms. Ask said it address actual utilization.

Sen. Franklin asked Ms. Ask to clarify "unbundled services." Ms. Ask said that is when there are different rates for different services and the subtotal is higher than the original total.

Sen. Towe asked Ms. Ask if she was satisfied with 15%. Ms. Ask said she was.

Ms. Case said that her amendments stated that the classifications the insurance company uses must be made known to the insured. Ms. Roy said this just asks for disclosure to insureds of the rating system.

Call to Order: By Senator Dorothy Eck, Chair, on February 18, 1993, at 6:45 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)
Sen. Tom Towe (D)

Members Excused: None.

Members Absent: None.

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

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

Committee Business Summary:
Hearing: None.
Executive Action: SB 285, SB 237, SB 267

Chairman Eck said that the Committee would take action on the amendments submitted. Chairman Eck explained that the Committee had gone through the insurance section, and the unwritten amendments submitted by Melissa Case. Chairman Eck asked for a recommendation for addressing those amendments.

Sen. Towe said that Ms. Case made some good points, but he was nervous about adopting these. The Insurance Commissioner's amendments are already "pretty revolutionary", and the Committee should stick with those amendments. Sen. Towe said he was "very concerned" that rates would increase by bringing rate bands closer together, and for that reason he suggested that the Committee not endorse Ms. Case's amendments.

Sen. Christiaens said he had concerns that with the adoption of amendments, the bill would be changed from what so many unanimously support. Sen. Christiaens said it is important that the bill be kept "as clean as it can", and let the House work on it.

Chairman Eck said that Rep. Fagg's bill dealing with insurance reform has not been heard in the House yet, and it might be good to participate in those hearings as well. Chairman Eck suggested the Committee address the amendments before the Committee.

Sen. Rye said he was the only member of the Committee that supported Sen. Yellowtail's bill, SB 267.

Chairman Eck said there should be an official amendment to work with the "gray bill"

Motion/Vote:

Sen. Towe moved the amendments reflected in the gray bill. (Exhibit #1) The motion carried unanimously.

Discussion:

Sen. Rye went over an amendment from Montanans for Universal Health Care. (Exhibit #2)

Sen. Franklin said that a voluntary board was not inconsistent with other policy-making state boards, there would be a paid staff as well. There were concerns about creating another state entity or agency, but the Authority will have the flexibility for alteration.

Clyde Dailey said there was too much to be done for a voluntary board over the two-year period of time. A voluntary board may not be as effective as a paid board, and a voluntary board could be dominated by ex-officio members.

Motion:

Sen. Rye said he did not support the amendment, but he moved it anyway.

Discussion:

Sen. Towe said he was persuaded that for serious health care board, a voluntary board which meets only a couple of times per month is a real concern. He said that he understands Sen. Franklin's concerns, but a voluntary board might not be made up of the best people. Sen. Towe said that in the future he was going to make a proposal that the members of the Health Care Authority be elected.

Sen. Klampe asked what the proposed salary would be. Clyde Dailey said it would be close to $34,000.00 per year.

Sen. Klampe said it would be difficult to get four "experts in the field" to work for the Authority at that salary.

Sen. Christiaens said he had concerns with the "mood of this legislature." $34,000.00 isn't nearly enough, and he has concerns that the legislation may not pass because of the dollar value.

Sen. Rye asked Sen. Franklin to explain how many people worked on this legislation with no remuneration. Sen. Franklin said this legislation was compelling, and it came together even without the help of staff. She feels that a significant amount of work can be done by a voluntary board, especially with the help of a paid staff.

Vote:

The motion failed with all Committee members voting no, except Sen. Towe who voted yes.

Motion:

Sen. Rye moved another amendment from Montanans for Universal Health Care. (Exhibit #3)

Discussion:

Christian Mackay went over the amendments, which address the health regions.

Sen. Mesaros said he supported these amendments because rural health care is a key issue. One representative per county would assure rural representation.

Chairman Eck said the Health Department regions are those used by the Department of Mental Health. There would be 17 counties in one region. They were established by MACO.

Sen. Franklin said that SB 285 originally did not set regions at all, and it would be left to the Authority. There is an argument that valuable time could be saved by not arguing over health care regions if it were done by the Legislature.

Sen. Towe asked Sen. Franklin what her preference was. Sen. Franklin said she preferred the Health Department amendments.

Chairman Eck said, without objection, the motion would be divided and the amendments to Sections 3, 4 and 5 would be voted on.

Vote:

The motion passed unanimously.

Substitute Motion:

Sen. Franklin made a substitute motion that the Committee accept the 5th amendment from the Health Department for the health care regions. (Exhibit #4)

Discussion:

Christian Mackay said he understands the rationale of going with pre-established regions, but they oppose the 17-county region which is Eastern Montana. Too much of Eastern Montana is put in one district and there is the potential for under representation of the rural areas.

Sen. Franklin said that would be mitigated because there would be a representative from each county.

Mr. Mackay asked if they were the mental health regions.

Chairman Eck said the regions were set up when the federal government was pushing for regions. There are some agencies that have not adopted these regions.

Sen. Mesaros asked Chairman Eck how many entities used the established regions being referred to. Chairman Eck said they are used by the Human Resource development Council (HRDC), as well as many other agencies.

Sen. Franklin suggested that perhaps this could be changed in the House, but she preferred the Department of Health's regions.

Clyde Dailey said the fact that the regions are established so that the Authority will not have to spend time determining the regions is more important that which regions are chosen by the Committee.

Vote:

The motion to accept the substitute amendment passed with all Committee members voting yes, except Sen. Rye who voted no.

Motion:

Sen. Rye moved the amendments from the Montana Medical Association. (Exhibit #5)

Discussion:

Sen. Towe said the page numbers in the amendments refer to the original bill. Sen. Towe went over the first amendment. He said the uniform system of benefits was critical and should stay, and should not be eliminated. Therefore, he doesn't think the Committee should adopt the first amendment.

Sen. Franklin also asked the Committee to reject the first amendment.

Sen. Towe went over the second amendment from the Montana Medical Association. He urged the Committee to reject the second amendment because he felt it was not needed. Sen. Towe continued with the third amendment, which he said was already proposed by the Montana Association of Life Underwriters. He urged the Committee to reject the third amendment.

Sen. Franklin said the cost-containment language in SB 285 is critical. The position must be taken that SB 285 is an "implementation bill" and not merely a study.

Sen. Klampe said he disagrees with Sen. Towe and Sen. Franklin regarding the third amendment. Sen. Klampe said "we don't even know what global budgeting is." Unless it can be strongly defined, it should not be included in the bill.

Sen. Franklin said the Health Care Authority has the ability to define what is appropriate within the context of their actions. Sen. Franklin said she didn't think it was a problem to charge the Authority to act responsibly and to determine what is appropriate under their charges. "Shall strongly consider" is a very different message in a piece of legislation, and it needs to be avoided.

Sen. Klampe said the same argument could be made for "shall strongly consider."

Chairman Eck asked Clyde Dailey if this had been proposed a number of times and always rejected. Mr. Dailey said that, as a spectator of the meetings, the message was clear that global budgeting was a key component to the legislation and there was enough flexibility given to the Authority to develop and implement global budgeting. It was a key component to cost containment and access. During the discussions, it was agreed that it was key.

Sen. Christiaens said he agreed with Sen. Klampe that "shall" means that nothing else is considered, and the language should be open enough for the Authority to look at all options.

Sen. Towe said he knew how committees such as the Authority operate, and he had no worries that different proposals will be considered.

Sen. Klampe said the language should read "should strongly consider."

Sen. Towe said the Committee should leave the language the way it is currently written.

Sen. Franklin said the language must be strong so there is no risk of a "study bill" which is probably "the worst case scenario." Sen. Franklin said an implementation bill is needed.

Sen. Towe said that Sen. Klampe would probably want to segregate the third amendment. Sen. Towe continued with the fourth amendment regarding cost shifting. He said the amendment sounded like an editorial comment, and was not really needed in SB 285.

Sen. Towe went over the fifth amendment from the Montana Medical Association.

Sen. Franklin said there is a system called RDRVS used as a reimbursement system for netted care. Sen. Franklin said it would be "skewing" to include it in the body of SB 285. The Authority is not wed to the RDRVS system, but they can look to it as the current language is written. It is too pointed to pick out a particular system.

Sen. Christiaens asked Sen. Franklin if it were similar to DRG's.

Sen. Franklin said it wasn't similar to DRG's.

Larry Akey said RDRVS is comparable worth provided for medical services.

Chairman Eck said there was the argument that because of training and education, some providers should be paid more than others.

Sen. Franklin said RDRVS provides some controls as to how providers can charge for their services.

Tanya Ask said it always recognizes primary care and the cognitive work that is provided as a primary care provider in relation to procedural services. It is to keep from overcompensating a specialist and undercompensating a generalist.

Sen. Franklin said the RDRVS system is valuable but she has concerns that it is too specific to be included in the bill.

Clyde Dailey said it is a primary methodology for Medicare reimbursement, and he agrees with Sen. Franklin that the Authority should be able to use their own methodology for payment because there are many choices.

Sen. Klampe asked Tanya Ask to address the first amendment offered by the Montana Medical Association. Ms. Ask said the thoughts behind the inclusion of "necessary and effective health care benefits" was to allow for evaluation of a particular service.

Sen. Franklin said this was addressed elsewhere in SB 285.

Sen. Towe pointed out that part of SB 285.

Chairman Eck asked if the Committee wanted to segregate the amendments.

Sen. Klampe requested that the third amendment be segregated.

Chairman Eck said the vote would be on amendments 1, 2, 4, and 5 from the Montana Medical Association.

Vote:

The motion failed unanimously.

Discussion:

Susan Fox said that "most strongly consider" was redundant, and offered "strongly consider."

Chairman Eck accepted this as a friendly amendment.

Vote:

The motion to accept the third amendment from the Montana Medical Association was recorded as a role call vote. (Exhibit #6) The motion failed 2-6.

Motion:

Sen. Rye moved the amendments offered by the Montana Association of Life Underwriters. (Exhibit #7)

Discussion:

Larry Akey said the page numbers had been changed to coordinate with the new bill. Mr. Akey went over the amendments from the Montana Association of Life Underwriters (MALU).

Sen. Towe said he liked the first part of the fifth amendment (d), but the language should stop after the word "procedures" because the addition of the limitation of liability shouldn't be addressed at this point of the bill.

Sen. Franklin said the Committee should first decide a procedure for addressing the amendments.

Chairman Eck asked Mr. Akey to continue, and go through all the amendments.

Mr. Akey continued to go over the MALU amendments. Mr. Akey said they suggest that Line 3 on Page 16 of the new bill, "shall" be changed to "may" so that the Insurance Commissioner is not required to adopt a uniform claims form if one is not actually developed. This amendment replaces amendments 7-9 in the MALU amendments provided to the Committee.

Sen. Franklin said she had a problem with the first MALU amendment because SB 285 makes a conceptual statement that a recommendation will be made for a regulated multi-payor and a regulated single-payor system. If nobody is happy with either of these, Sen. Franklin proposes the Committee adopt an amendment offered by the Department of Health that gives clear language regarding the legislature voting on these plans. Also, the language states that the legislature may return one or both plans to the Authority for further development. Therefore, she would resist the first amendment. As for the fifth amendment regarding a system for reducing the use of defensive medicine by adopting practice protocols. She resists this because the bill addresses this already regarding the whole issue of defensive medicine. Sen. Franklin said practice protocols is an issue, but nationally, there are none.

Larry Akey said the same thing could be said for global budgeting, because it does not exist in the United States and SB 285 states that the authority must do global budgeting.

Sen. Franklin said they were out of the area in terms of

insurance reform, and she feels comfortable that the health care providers will address that.

Sen. Towe said he disagreed.

Sen. Franklin said regarding cost benefit analysis of mandated benefits, the language in SB 285 about regulating demand of services or unnecessary and inappropriate care indicates purpose without the specific issue of mandates.

Sen. Klampe said that it seemed to him that sometimes Sen. Franklin wanted to be conceptual and definite.

Sen. Franklin said there is a struggle with broad concepts and the amount of detail which can be worked with. Individual needs must be addressed while protecting the body of the bill.

Sen. Towe asked Larry Akey what was "cost effective" in this context. Mr. Akey said it was a term of "art" in cost benefit analysis.

Sen. Towe said it was his understanding that cost must be looked at in dollars and cents while sometimes health care was not measured in dollars and cents. By mandating services, more people would get the benefits and assistance they wouldn't otherwise receive. For that reason, Sen. Towe said he wasn't sure it was a good idea to determine whether or not each of the mandated benefits should be kept on the basis of cost effectiveness. His other concern was this could be the subject for a whole new study, and the Authority maybe should not be "bogged down" with such a large study.

Carol Roy reminded the Committee that HB 75 addressed the review of mandated benefits.

Sen. Christiaens asked Sen. Towe how it would be decided that a mandated benefit would be cost effective. Sen. Towe, regarding mental health, it may cost more at a later date if the problems are not addressed now. Sen. Towe said he was not sure the desire to save money should motivate someone to support or not to support the idea of a mandated benefit.

Chairman Eck suggested the Committee look at the language under (b) on Page 11 of the new bill. Chairman Eck went over the language.

Sen. Christiaens said that language was broader than what was presented in the amendment.

Chairman Eck said that was correct.

Sen. Towe said the Committee would not have to worry too much about the Health Care Authority because they'll do whatever they want to do, regardless what the legislature tells them to do.

Sen. Klampe said cost benefit analysis is a huge problem to address, and it needs to be addressed on a national level or by a body that has the money to pay for the studies.

Sen. Towe said he liked the sixth MALU amendment regarding public education. He thinks everyone should join together to educate the public.

Clyde Dailey said it could be potentially divisive in communities where the local insurance agent would be asked to define health care reform, while that individual has a vested interest in it. Mr. Dailey said this could be seen as asking the agent to sell insurance.

Sen. Franklin said she would resist this amendment because the Authority should not have to direct health care insurers to be involved in the purpose and content of the state-wide plan.

Sen. Towe said they were not involved in the purpose and content of a state-wide plan, they would be educating the public concerning the purpose and content. Sen. Towe said the more people educating the public, the better.

Sen. Franklin said she would agree with that.

Sen. Towe asked that the amendments be divided. He asked for Sen. Franklin's comments on amendments 10 and 11.

Sen. Franklin said that regarding amendment 11, there is already language in the bill which addresses data being readily available to the public.

Sen. Towe said there is language in the bottom of Page 24 of the new bill that is close. Sen. Towe said Mr. Akey's proposed amendment compliments this language nicely.

Sen. Franklin said this does not necessarily need to be delineated as a separate task for the Authority. She said this could potentially be "obstructionist." Therefore, the language already in SB 285 addresses this.

Sen. Klampe said that within a region, this issue had not been addressed because there could be wide variations in cost.

Mr. Akey said that 80% of the care received is care that consumers have had the reasonable chance to pick the time and location of that care. For example, money might be saved going to one location instead of another. Why then, shouldn't the unified health care data not be used to develop this kind of information.

Sen. Klampe said there is a wide variation of prices between rural and urban areas in Montana.

Sen. Towe said making these price differences public might have an impact, and he thinks it makes good sense.

Carol Roy said this is already being done efficiently by insurers with the zip codes of where the services are provided. This information will be available to the Authority, and may help in planning global budgeting.

Sen. Franklin withdrew her objection to the amendment.

Sen. Towe went over amendment 10. He said it would allow the insurers to be a part of the anti-trust agreements, and he thought it made good sense.

Clyde Dailey asked John Flink how this would affect his proposed anti-trust amendment. Mr. Flink this is consistent with the overall concept.

Substitute Motion:

Sen. Towe made the substitute motion that the Committee adopt amendments 2, 6, 10, and 11 from the Montana Association of Life Underwriters.

Discussion:

Sen. Franklin said the second amendment could have a profound impact on the fiscal note because an actuary would be employed.

Mr. Akey said the only way to develop reasonable cost estimates and avoid a repeat of the worker's compensation problems is by employing an actuary.

Carol Roy said she agreed with Mr. Akey.

Sen. Towe asked Ms. Roy if she thought it should be done even if it cost more money. Ms. Roy said that was correct, and that it could be contracted out.

Tanya Ask said this was a comment made in an earlier meeting, that this would be one of the contracted services.

Sen. Christiaens said it makes good sense to save the money up front to avoid costs in the future.

Vote:

The motion to adopt amendments 2, 6, 10, and 11 passed unanimously.

Motion:

Sen. Towe moved that the Committee adopt amendment 5 part (d) until the word "procedures".

Discussion:

Carol Roy said treatment protocols are not yet defined.

Sen. Franklin said this could meet a lot of resistance because it is asking to go beyond what data is available.

Sen. Klampe said protocols and cost-benefit analysis are good ideas, and asked if language could be incorporated in SB 285 to suggest that they be considered. There may soon be federal guidelines.

Sen. Christiaens asked if this language should be included under "tort reform."

Sen. Franklin read the language Page 16, Section 11 of the new bill.

Sen. Towe withdrew his previous motion.

Motion:

Sen. Towe moved that the Committee adopt the following language: on Page 16, Section 11, after the word "shall" add the language "(i) conduct a study of a system for reducing the use of defensive medicine by adopting protocols which would give provider guidelines to follow for specific procedures; (ii) conduct a study of tort reform measures including limitations on the amount of non-economic damages; (iii) proposal for changes including legislation considered necessary including measures and compensating victims." These are then all studies.

Discussion:

Larry Akey said he would accept that.

Sen. Klampe said he would like cost-benefit analysis included in the tort reform section as well.

Sen. Franklin said she had concerns about practice protocols, because the Authority does not have the tools to adopt practice protocol guidelines.

Sen. Towe said it was moved to a study.

Sen. Christiaens said it made sense.

Vote:

The motion carried unanimously.

Discussion:

Sen. Klampe suggested that on Page 11 under the "cost

containment" section, "the concept of a cost-benefit analysis" be inserted.

Sen. Towe asked Sen. Klampe for what the cost-benefit analysis would be. Sen. Klampe said it would be for procedures.

Sen. Towe asked Sen. Klampe if it would not be of mandated benefits. Sen. Klampe said it would be of mandated benefits.

Carol Roy said mandated benefits is a big topic and there has been a study on how to study mandated benefits. It may be better to start a trust fund.

Sen. Franklin said it would be better not to include cost-benefit analysis.

Larry Akey said HB 75 addresses this issue. Mr. Akey said there was still the amendment replacing "shall" to "may" on Page 16, Line 3.

Sen. Towe said he chose not to address that amendment.

Motion:

Sen. Christiaens moved that on Page 16, Line 3, the word "shall" be replaced with "may".

Discussion:

Sen. Franklin said the language was then highly permissive.

Sen. Towe said he was reluctant to change the word because it was a very important aspect of SB 285 to get uniformity of insurance claims. At the national level, if there is not a uniform claim developed by the next legislature, then work should begin on a uniform claim within the state of Montana.

Sen. Christiaens said there are some uniform claims existing already.

Chairman Eck said her bill, SB 237, addressed that, and she was going to ask the Committee to Table that bill.

Larry Akey said a group of the National Association of Insurers was working with other group to develop a uniform claims form.

Chairman Eck said it was her understanding that in some cases standardized forms are not needed because of advanced computer software available.

Carol Roy said this is an issue because the Insurance Commissioner is working on implementing rules, and they will be possibly charged with mandated benefits. There needs to be sufficient time to implement standardized claims forms.

Sen. Towe suggested that "by January 1, 1994" be taken out.

Sen. Christiaens said that was why changing "shall" to "may" makes sense.

Pat Wise said it is important that uniform claims forms be implemented.

Sen. Franklin said that if the date was not appropriate, it could be negotiated.

Vote:

The motion to change "shall" to "may" passed 5-3, with Sen. Towe, Chairman Eck and Sen. Franklin voting no.

Motion/Vote:

Sen. Franklin moved the friendly amendments 1, 2, 3, and 4 to SB 285 from the Health Department. (Exhibit #4) The motion carried unanimously.

Discussion:

Chairman Eck said the Committee should give Tom Gomez the direction to amend the title if appropriate and make other necessary changes.

Motion:

Sen. Franklin moved that the Committee should give Tom Gomez the direction to amend the title if appropriate and make other necessary changes. The motion passed unanimously.

Discussion:

Sen. Franklin said there was a recommendation that there be clear language that both plans must be voted on by the 1995 Legislature because there were concerns that SB 285 would be seen as a "study bill."

Sen. Towe said that language should be added on Page 7, Line 25 of the original bill. Sen. Towe suggested the language, "Neither plan shall be effective without Legislative approval." be added.

Sen. Christiaens said there was good language proposed in the sixth amendment from the Friendly Amendments to SB 285. (Exhibit #4)

Sen. Franklin said the sentence that reads "The Legislature may not amend either plan." should be stricken.

Sen. Towe said he thought this language would be more appropriate where he suggested it be rather that where it is suggested in the amendment.

Tom Gomez said in Page 9, at the top, in the new bill, the language has been already changed quite a bit already. Tom Gomez suggested that the first sentence of the sixth Friendly Amendment be added on Page 9 of the new bill.

Motion/Vote:

Sen. Franklin moved that amendment. The motion carried unanimously.

Motion/Vote:

Sen. Franklin moved the Committee adopt Amendment 7 from the Friendly Amendments. (Exhibit #4) The motion carried unanimously.

Discussion:

Sen. Franklin said the language in the eighth Friendly Amendment (Exhibit #4) is already in the body of SB 285, and none of the Committee members wanted to strike it. The language in the ninth Friendly Amendment had already been addressed. The tenth Friendly Amendment addressed the delegation of duties to the executive, and Sen. Franklin said she had no objections to that.

Motion/Vote:

Sen. Franklin moved the Committee adopt the tenth Friendly Amendment. The motion carried unanimously.

Discussion:

Sen. Franklin said the language in the eleventh Friendly Amendment was already addressed in SB 285.

Sen. Towe said he still had concerns with the eighth Friendly Amendment (Exhibit #4). He said that usurping the appropriate powers of the board of directors of a health care facility is "really not necessary."

Sen. Franklin asked John Flink to address this issue.

Mr. Flink said a hospital board of trustees is a community-based group that makes decisions about that facility and the health care services to be provided. They are also responsible for the financial standing of the facility. Mr. Flink said it this was a sensitive issue, and he could understand wanting to give the authority to the Health Care Authority to make strong recommendations to a board of directors. However, hospitals will

have difficulty with having certain powers usurped.

Sen. Towe said what bothered him was a "vigorous" hospital board would not pay any attention to what the Authority asked.

Sen. Franklin said she would support the eighth Friendly Amendment in light of the discussion.

Motion/Vote:

Sen. Towe moved the Committee adopt the eighth Friendly Amendment (Exhibit #4). The motion carried unanimously.

Discussion:

Tom Gomez said in the tenth Friendly Amendment is not necessary because the language has already been incorporated from SB 267 into SB 285.

Motion/Vote:

Sen. Franklin moved that the Committee strike the tenth Friendly Amendment (Exhibit #4). The motion carried unanimously.

Motion/Vote:

Sen. Christiaens moved that SB 285 DO PASS AS AMENDED. The motion carried unanimously.

Motion/Vote:

Sen. Towe moved that SB 237 BE TABLED. The motion carried unanimously.

Motion/Vote:

Sen. Klampe moved that SB 267 BE TABLED. The motion carried unanimously.

Discussion:

Sen. Towe asked to reserve the right to bring up the issue of anti-trust on the Floor of the Senate.

ADJOURNMENT

Adjournment: Chairman Eck adjourned the meeting at 9:40 p.m.

SENATOR DOROTHY ECK, Chair

LAURA TURMAN, Secretary

DE/LT

ROLL CALL

SENATE COMMITTEE Public Health DATE 2-18-93

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

FC8

Attach to each day's minutes

SENATE STANDING COMMITTEE REPORT

February 20, 1993

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration Senate Bill No. 285 (first reading copy -- white), respectfully report that Senate Bill No. 285 be amended as follows and as so amended do pass.

Signed: Dorothy Eck
Senator Dorothy Eck, Chair

That such amendments read:

1. Title, lines 11 through 13.
Following: line 10
Strike: line 11 through "BOARDS" on line 13
Insert: "REQUIRING DEVELOPMENT OF UNIFORM CLAIM FORMS AND PROCEDURES; REQUIRING THE AUTHORITY TO CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL HEALTH CARE PLANNING BOARDS"

2. Title, lines 15 and 16.
Following: "BASE;" on line 15
Strike: remainder of line 15 through "REFORM" on line 16
Insert: "REQUIRING HEALTH INSURER COST MANAGEMENT PLANS"

3. Title, line 18.
Strike: "VITAL STATISTICS"
Insert: "STATE HEALTH PLANNING; PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT"

4. Title, line 19.
Strike: "50-15-101"
Insert: "50-1-201"

5. Page 1, line 23 through page 3, line 9.
Following: line 22
Strike: page 1, line 23 through page 3, line 9 in their entirety
Insert: "A statement of legislative intent is required for this bill because:

(1) [section 4] authorizes the Montana health care authority to adopt rules necessary to implement [sections 1 through 20]. In addition to those rulemaking matters addressed below, the authority may adopt rules governing such matters as its meetings, public hearings, and rules of procedure and rules of ethical conduct governing its members.

(2) [section 17] requires the Montana health care authority to adopt rules to establish regional health care planning boards within the health care planning regions established in [section 17] and to establish a procedure for selection of regional board members. 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. In addition, the rules must provide for consideration of a balance between rural and urban interests in the selection of regional board members. The procedure for selection of the board members must provide for public notice of the selection process.

(3) [section 10] grants the commissioner of insurance the authority to adopt rules specifying uniform health insurance claim forms and procedures. The forms should be based upon existing formats, be as short as possible, and be compatible with electronic data transmission.

(4) [section 19] 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 records, and must apply to employees of the authority and to others receiving or using records in the data base.

(5) [sections 23, 26, 27, 30, and 34 through 36] require 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 pursuant to the Small Employer Health Insurance Availability Act. The commissioner may adopt rules providing for a transition period to allow small employer carriers to comply with certain provisions of the act. The commissioner may approve the establishment of additional classes of businesses only if the commissioner determines that the additional classes would enhance the efficiency and fairness of the small employer health insurance market. The commissioner is required under the act to adopt rules to implement and administer the act."

6. Pages 3 through 23.
Strike: everything after the enacting clause
Insert: "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 care 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.

NEW SECTION. Section 2. Definitions. For the purposes of [sections 1 through 20], the following definitions apply:

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

(2) "Board" means one of the regional health care planning boards created pursuant to [section 17].

(3) "Data base" means the unified health care data base created pursuant to [section 19].

(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 service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator

of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

(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 8].

(8) "Region" means one of the health care planning regions created pursuant to [section 17].

(9) "Statewide plan" means one of the statewide universal health care access plans for access to health care required by [section 5].

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 appointed by the governor. At least one member must represent consumer organizations. Members of the authority must be appointed as follows:

(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 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 and the commissioner of insurance are nonvoting, ex officio members of the authority.

(8) A member shall acknowledge a direct conflict of interest in a proceeding in which the member has a personal or financial interest.

NEW SECTION. **Section 4. Administration of health care authority -- reports -- compensation.** (1) The authority shall employ a full-time executive director who shall conduct or direct the daily operation of the authority. The executive director is exempt from the application of 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 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 authority.

(2) The authority 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. However, the authority may not delegate its rulemaking powers under [sections 1 through 20].

(3) The authority 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 authority may:

(a) apply for and accept gifts, grants, or contributions from any person for purposes consistent with 50-1-201 and [sections 1 through 20];

(b) adopt rules necessary to implement [sections 1 through 20]; and

(c) enter into contracts and perform other acts necessary to accomplish the purposes of [sections 1 through 20].

(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 1 through 20]. Reports may be provided in a manner similar to 5-11-210 or in another manner determined by the authority.

(6) Members of the authority must be paid and reimbursed as provided in 2-15-124.

(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 access plans required. (1) 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 system and a recommendation for a statewide universal access plan based on a regulated multiple payor system. Each statewide plan must contain recommendations that, if implemented, would provide for universally accessible, medically necessary, and preventative health care by October 1, 1995. Both plans must be voted on by the 1995 legislature no later than 45 days from the first day of the 1995 legislative session. The legislature may return one or both plans to the authority for further development.

(2) For purposes of this section:

(a) a single payor system is a method of financing health services predominately through public funds so that each resident of Montana receives a uniform set of benefits as established through statute or administrative rule. Policies governing all aspects of the management of the single payor system would reside with state government, and benefits must be administered by a single entity;

(b) a regulated multiple payor system is a method of financing health services through a mix of public and private funds so that each resident of Montana receives a uniform set of benefits as established by statute or administrative rule. State government has responsibility for regulating the multiple entities that provide benefits to residents, including regulations for enrollment, change in premium rates, payment rates to providers, and aggregate health expenditures.

NEW SECTION. Section 6. Features of statewide plans. (1) Each statewide plan under [section 5] must contain the features required by [sections 7 through 9 and 11] and this section.

(2) Each statewide plan must include:

(a) guaranteed access to health care services for all residents of Montana;

(b) a uniform system of health care benefits;

(c) a unified health care budget;

(d) portability of coverage, regardless of job status;

(e) a broad-based, public or private financing mechanism to fund health care services;

(f) a system capped for provider expenditures;

(g) global budgeting for all health care spending;

(h) controlled capital expenditures;

(i) a binding cap on overall expenditures;

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

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

(l) administrative efficiencies;

(m) the appropriate use of midlevel practitioners, such as physician's assistants and nurse practitioners;

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

(o) integration, to the extent possible under federal and state law, of benefits provided under the health care system with benefits provided by the Indian health service and the United States department of veteran affairs and benefits provided by the medicare and medicaid programs; and

(p) an actuarially sound estimate of the costs of implementing the plan through the year 2005.

NEW SECTION. **Section 7. 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 authority shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the target required in subsection (1), including such factors as population increases or decreases, demographic changes, costs beyond the control of health care providers, and other factors that the authority considers significant.

(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, health insurers, and health care facilities to educate the public concerning the purpose and content of the statewide plans.

NEW SECTION. **Section 8. Health care resource management plan.** (1) Each statewide plan must contain a health care resource management plan that takes into account the provisions of [section 7]. The management plan must provide for the distribution of health care resources within the regions established pursuant to [section 17] and within the state as a whole, consistent with the principles provided in subsection (2).

(2) The management 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;

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

(f) incentives for healthy lifestyles;

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

(i) 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

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

(h) 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 medicare and medicaid programs.

(3) In adopting the management plan, the authority shall consider the regional health resource plans recommended by regional panels.

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

(5) Prior to adoption of the management plan, the authority 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 authority shall adopt the management plan, taking comments into consideration.

NEW SECTION. **Section 9. Health care billing simplification.** (1) Each statewide plan must contain a component providing for simplification and reduction of the 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; and

(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.

(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 phasein 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 10. Uniform claim forms and procedures.** (1) By January 1, 1994, the commissioner of insurance, after consultation with the authority, may 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 claims by means of an electronic claims processing system.

(2) The commissioner may contract with a private or public entity to administer and operate an electronic claims processing system. If the commissioner elects to contract for administration and operation of the system, the commissioner shall award a contract according to Title 18, chapter 4.

NEW SECTION. **Section 11. 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) (a) In order to reduce the costs of defensive medicine, the authority shall:

(i) conduct a study of a system for reducing the use of defensive medicine by adopting practice protocols that would give providers guidelines to follow for specific procedures;

(ii) 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

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

(b) As part of its study under subsection (2)(a)(ii), 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 authority shall conduct a study of the impacts of federal and state antitrust laws on health care services in the state and make recommendations, including legislation, to address those laws and impacts. The authority shall include in its plans legislation that will enable health care providers and payors, including health insurers and consumers, to negotiate and enter into agreements when the agreements are likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. In proposing appropriate legislation concerning antitrust laws, the authority shall provide appropriate conditions, supervision, and regulation to protect against private abuse of economic power.

(4) 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 12. Hearings on statewide plans.** The authority shall seek public comment on the development of each statewide plan required under [section 5]. In seeking public comment on the development of the authority's recommendations for each plan, the authority 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 17]. The hearings must take place before the authority's report is submitted to the legislature. The authority shall consult with health care providers in the development of its recommendations for each statewide plan.

NEW SECTION. **Section 13. State purchasing pool -- reports required.** (1) On or before December 15, 1994, and December 15, 1996, the authority shall report to the legislature on establishment of a state 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 authority.

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

NEW SECTION. **Section 14. 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 authority's recommendations for any necessary legislation, must be reported to the legislature by December 1, 1996. If the authority determines that feasible methods are available without need for legislation or appropriations, the authority shall implement that part or those parts of its recommendations.

NEW SECTION. **Section 15. Long-term care study and recommendations.** (1) 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 17]. 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 authority'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 authority'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 is no change in the present accessibility, affordability, or financing of long-term care services in this state.

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

NEW SECTION. **Section 16. Study of certificate of need process.** (1) The authority 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 authority's recommendation for a single payor health care system required by [section 5]. 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.

NEW SECTION. **Section 17. Health care planning regions and regional planning boards created -- selection -- membership.** (1) There are five health care planning regions. Subject to subsection (2), the regions must consist of the following counties:

(a) region I: Sheridan, Daniels, Valley, Phillips, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River, and Carter;

(b) region II: Blaine, Hill, Liberty, Toole, Glacier, Pondera, Teton, Chouteau, and Cascade;

(c) region III: Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet Grass, Stillwater, Yellowstone, Carbon, and Big Horn;

(d) region IV: Lewis and Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park, Gallatin, Madison, and Beaverhead;

(e) region V: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli.

(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. The authority shall give notice as the authority determines appropriate. 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 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 authority.

(3) Within each region, the authority shall establish by rule a regional health care planning board. Each board must include one member from each county within the region. The members on each board shall represent a balance of individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care. Each regional board should attempt to achieve gender balance.

(4) 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 the 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.

(5) Regional board members serve 4-year terms, except that of the board members initially selected, at least three members serve for 2 years, at least three members serve for 3 years, and at least three 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 18. Powers and duties of boards.** (1) A board shall:

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

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

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

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

(e) revise the regional plan annually;

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

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

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

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

(2) Regional boards may:

(a) 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;

(b) 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;

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

(d) 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.

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

NEW SECTION. **Section 19. 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;

(d) compare costs of commonly performed health care procedures between providers and health care facilities within a region and make the data readily available to the public; and

(e) 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, 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.

NEW SECTION. **Section 20. 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 authority no later than January 1, 1994.

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

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

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

Section 21. 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 ~~a~~gency 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 now available or which may be~~ donated, granted, bequeathed, or appropriated to it for the preparation, ~~and~~ administration, and

~~the~~ supervision of the preparation and administration of the comprehensive state health plan."

NEW SECTION. Section 22. Short title. [Sections 22 through 36] may be cited as the "Small Employer Health Insurance Availability Act".

NEW SECTION. Section 23. Purpose. (1) [Sections 22 through 36] must be interpreted and construed to effectuate the following express legislative purposes:

(a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;

(b) to prevent abusive rating practices;

(c) to require disclosure of rating practices to purchasers;

(d) to establish rules regarding renewability of coverage;

(e) to establish limitations on the use of preexisting condition exclusions;

(f) to provide for the development of basic and standard health benefit plans to be offered to all small employers;

(g) to provide for the establishment of a reinsurance program; and

(h) to improve the overall fairness and efficiency of the small employer health insurance market.

(2) [Sections 22 through 36] are not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

NEW SECTION. Section 24. Definitions. As used in [sections 22 through 36], the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of [section 27], based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to [section 31].

(5) "Board" means the board of directors of the program established pursuant to [section 30].

(6) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For purposes of [sections 22 through 36], companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(7) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claims experience, health status, and duration of coverage are not case characteristics for purposes of [sections 22 through 36].

(8) "Class of business" means all or a separate grouping of small employers established pursuant to [section 26].

(9) "Committee" means the health benefit plan committee created pursuant to [section 31].

(10) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined to be a dependent in the health benefit plan covering the employee.

(11) "Eligible employee" means an employee who works on a full-time basis and who has a normal workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The

term does not include an employee who works on a part-time, temporary, or substitute basis.

(12) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(13) "Health benefit plan" means any hospital or medical policy or certificate issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

(14) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(15) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual meets each of the following conditions:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(16) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small

employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(17) "Plan of operation" means the operation of the program established pursuant to [section 30].

(18) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(19) "Program" means the Montana small employer health reinsurance program created by [section 30].

(20) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

(21) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(22) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to [section 30].

(23) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(24) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer.

(25) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(26) "Standard health benefit plan" means a health benefit plan developed pursuant to [section 31].

NEW SECTION. **Section 25. Applicability and scope.** [Sections 22 through 35] apply to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) a portion of the premium or benefits is paid by or on behalf of the small employer;

(2) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

NEW SECTION. **Section 26. Establishment of classes of business.** (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs that are related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

(b) The small employer carrier has acquired a class of business from another small employer carrier.

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of 33-22-501(2).

(2) A small employer carrier may establish up to nine separate classes of business under subsection (1).

(3) The commissioner may adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the case of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

NEW SECTION. **Section 27. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans under [sections 22 through 36] are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business:

(i) the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate; or

(ii) if the Montana health care authority established by [section 3] certifies to the commissioner that the cost containment goal set forth in [section 7] is met on or before January 1, 1999, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage may not vary from the index by more than 20% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) Premium rates for health benefit plans must comply with the requirements of this section, notwithstanding any assessments paid or payable by small employer carriers pursuant to [section 30].

(f) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the

average of the rate factors associated with all industry classifications by more than 15% of that coverage.

(g) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

(ii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(h) A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(i) For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

(j) The small employer carrier may not use case characteristics, other than age, without prior approval of the commissioner.

(k) The commissioner may adopt rules to implement the provisions of this section and to ensure that rating practices used by small employer carriers are consistent with the purposes of [sections 22 through 36], including rules that ensure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences because of the nature of the groups.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of the following:

(a) the extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or upon the actual or expected variation in health status of the employees of small employers and the employees' dependents;

(b) the provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claims experience, that affect changes in premium rates;

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions relating to any preexisting condition.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with [sections 22 through 36] and that the rating methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of [sections 22 through 36] and except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

NEW SECTION. **Section 28. Renewability of coverage.** (1) A health benefit plan subject to the provisions of [sections 22 through 36] is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

(b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;

(c) noncompliance with the carrier's minimum participation requirements;

(d) noncompliance with the carrier's employer contribution requirements;

(e) repeated misuse of a restricted network provision;

(f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:

(i) provide advance notice of this decision under this subsection (1) (f) to the commissioner in each state in which it is licensed; and

(ii) at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the affected small employers.

(g) the commissioner finds that the continuation of the coverage would:

(i) not be in the best interests of the policyholders or certificate holders; or

(ii) impair the carrier's ability to meet its contractual obligations.

(2) If the commissioner makes a finding under subsection (1)(g), the commissioner shall assist affected small employers in finding replacement coverage.

(3) A small employer carrier that elects not to renew a health benefit plan under subsection (1)(f) is prohibited from writing new business in the small employer market in this state

for a period of 5 years from the date of notice to the commissioner.

(4) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section apply only to the carrier's operations in that service area.

NEW SECTION. **Section 29. Availability of coverage -- required plans.** (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with [sections 22 through 36].

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to [section 26], the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) The provisions of this section are effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to [section 31], provided that if the program created pursuant to [section 30] is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of [sections 22 through 36].

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively than 33-22-216, except that the condition may be excluded for a maximum of 12 months.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition.

NEW SECTION. **Section 30. Small employer carrier reinsurance program -- board membership -- plan of operation -- criteria -- exemption from taxation.** (1) There is a nonprofit entity to be known as the Montana small employer health reinsurance program.

(2) (a) The program must operate subject to the supervision and control of the board. The board consists of nine members appointed by the commissioner plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of

the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of business or in the practice of a profession. One member of the board must be a small employer who is not active in the health care or insurance fields. One member of the board must be a representative of the general public who is employed by a small employer and is not employed in the health care or insurance fields.

(ii) The initial board members' terms are as follows: one-third of the members shall serve a term of 1 year; one-third of the members shall serve a term of 2 years; and one-third of the members shall serve a term of 3 years. Subsequent board members shall serve for a term of 3 years. A board member's term continues until that member's successor is appointed.

(iii) A vacancy on the board must be filled by the commissioner. The commissioner may remove a board member for cause.

(3) Within [60 days of the effective date of this section], each small employer carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued to small employers in this state in the previous calendar year.

(4) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(5) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(6) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

(e) provide for any additional matters necessary for the implementation and administration of the program.

(7) The program must have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program must have the specific authority to:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of [sections 22 through 36], including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of [sections 22 through 36];

(e) establish rules, conditions, and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program; and

(h) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(8) A reinsuring carrier may reinsure with the program as provided for in this subsection (8):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next $100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of $25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group business in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(9) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must

include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (9)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under [sections 22 through 36].

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (9).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (9).

(c) The board periodically shall review the methodology established under subsection (9)(a), including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(10) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in [section 27].

(11) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) A net loss for the year must be reimbursed by the commissioner from funds specifically appropriated for that purpose.

(12) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by [sections 22 through 36] may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

(13) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(14) The program is exempt from taxation.

NEW SECTION. **Section 31. Health benefit plan committee -- recommendations.** (1) The commissioner shall appoint a health benefit plan committee. The committee is composed of representatives of carriers, small employers and employees, health care providers, and producers.

(2) The committee shall recommend the form and level of coverages to be made by small employer carriers pursuant to [section 29].

(3) (a) The committee shall recommend benefit levels, cost-sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan that contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(b) The plans recommended by the committee must include cost containment features, such as:

(i) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(ii) case management;

(iii) selective contracting with hospitals, physicians, and other health care providers;

(iv) reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(v) other managed care provisions.

(c) The committee shall submit the health benefit plans described in subsections (3)(a) and (3)(b) to the commissioner for approval within 180 days after the appointment of the committee.

NEW SECTION. **Section 32. Periodic market evaluation -- report.** The board, in consultation with members of the committee, shall study and report at least every 3 years to the commissioner on the effectiveness of [sections 22 through 36].

The report must analyze the effectiveness of [sections 22 through 36] in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of [sections 22 through 36]. The report may contain recommendations for market conduct or other regulatory standards or action.

NEW SECTION. **Section 33. Waiver of certain laws.** A law that requires the inclusion of a specific category of licensed health care practitioner does not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to [sections 22 through 36].

NEW SECTION. **Section 34. Administrative procedure.** The commissioner shall adopt rules in accordance with the Montana Administrative Procedure Act to implement and administer [sections 22 through 36].

NEW SECTION. **Section 35. Standards to ensure fair marketing.** (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage other than the basic or standard health benefit plans to a small employer on the basis of claims experience of the small employer or the health status or claims experience of its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

(2) (a) Except as provided in subsection (2)(b), a small employer carrier or producer may not directly or indirectly engage in the following activities:

(i) encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.

(8) The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9) (a) A violation of this section by a small employer carrier or a producer is an unfair trade practice under 33-18-102.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier.

NEW SECTION. Section 36. Restoration of terminated coverage. The commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with

small employers in this state after [the effective date of this section], to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after [6 months prior to the effective date of this section]. The commissioner may prescribe the terms for the reissuance of coverage that the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

NEW SECTION. **Section 37. Codification instructions.**

(1) [Sections 1 through 20] are intended to be codified as an integral part of Title 50, and the provisions of Title 50 apply to [sections 1 through 20].

(2) [Sections 22 through 36] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 22 through 36].

NEW SECTION. **Section 38. Effective dates.** (1) [Sections 1 through 20, 37, and this section] are effective on passage and approval.

(2) [Section 21] is effective July 1, 1996.

(3) [Sections 22 through 36] are effective January 1, 1994."

-END-

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 2-18-93
BILL NO. SB 285

ROLL CALL VOTE

SENATE COMMITTEE Public Health BILL NO. SB285

DATE 2-18-93 TIME 8:10 A.M. (P.M.)

NAME	YES	NO
CHRISTIAENS	✓	
HAGER		✓
KLAMPE	✓	
MESAROS		✓
RYE		✓
TOWE		✓
FRANKLIN		✓
ECK		✓

Laura Inman
SECRETARY

Sen. Dorothy Eck
CHAIR

MOTION: To accept the third amendment offered by the Montana Medical Associatio

F09

Senate Public Health, Welfare,
and Safety Committee
February 18, 1993
Senate Bill No. 285

Exhibit #1 of the February 18, 1993 meeting is a draft copy of Senate Bill No. 1. The original is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

Amendments to Senate Bill 285
as proposed by Montanans for Universal Health Care

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2-18-93
BILL NO. SB285

Page 8, Section 4, Subsection 4

Strike: Subsection 4 in its entirety

Insert: "(4) 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."

Amendments to Senate Bill 285
as proposed by Montanans for Universal Health Care

SENATE HEALTH & WELFARE
EXHIBIT NO. 3
DATE 2-18-93
BILL NO. SB 285

Page 21, Section 17, Subsection 1

Strike Subsection 1 in its entirety.

Insert: "(1) There are five health care planning regions. Subject to subsection 2, the regions consist of the following counties.

(a) Region I: Valley, Daniels, Sheridan, Roosevelt, Garfield, McCone, Richland, Dawson, Wibaux, Prairie, Fallon, and Carter;

(b) Region II: Glacier, Toole, Liberty, Hill, Blaine, Phillips, Pondera, Chouteau, Teton, Cascade, Judith Basin, and Fergus;

(c) Region III: Custer, Powder River, Rosebud, Treasure, Petroleum, Musselshell, Golden Valley, Wheatland, Stillwater, Yellowstone, and Carbon;

(d) Region IV: 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;"

Page 21, Section 17, Subsection 3

Strike: "Each board must have five members and must include individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both, in health care."

Insert: "Each board must include one member from each county within their respective region. The members on each board must represent a balance of individuals who are health care consumers and individuals who are recognized for their interest or expertise, or both in health care. Each regional board should achieve gender balance."

Subsection 4

Following: "The authority shall select"
Strike: "five"

Subsection 5

Strike: "one member serves"
Insert: "at least three members serve"

Strike: "two members serve for 3 years"
Insert: "at least three members serve for 3 years"

Strike: "two members serve for 4 years"
Insert: "at least three members serve for 4 years"

Friendly Amendments to S.285

Purpose of amendments 1 - 5: These amendments are from Charles Aagenes, State Department of Health and Environmental Sciences. They specify the five health care planning regions. If this amendment is not adopted, then the Authority may be required to spend considerable time establishing the regions. The regions suggested by Charles Aagenes meet the sponsor's intent.

1. Page 1, Statement of Intent, Line 25

Following: "authority to adopt rules"

Strike: "establishing a maximum of five health care planning regions,"

2. Page 2, Statement of Intent, Line 2

Following: "planning boards within"

Strike: "those regions"

Insert: "the health care planning regions established in [Section 10]."

3. Page 2, Statement of Intent, Line 3

Following: "board members."

Strike: "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 communications and transportation patterns and natural barriers to these patterns.

4. Page 2, Statement of Intent, Line 10

Following: "patterns. The"

Insert: "legislature intends that the"

5. Page 13, Section 10, Line 25

Following: "(1)"

Strike: "The authority shall by rule establish within the state a maximum of five health care planning regions that consist of

counties or parts of counties, or both. Regions must be established based principally upon the geographic health care patterns of referral by which the health care providers refer patients to specialists of health care facilities for more complex care. Each area of the state must be part of a region."

Insert: "The authority shall use the following health planning regions: Region 1: Sheridan, Daniels, Valley, Phillips, Roosevelt, Richland, McCone, Garfield, Dawson, Prairie, Wibaux, Fallon, Custer, Rosebud, Treasure, Powder River and Carter Counties; Region 2: Blaine, Hill, Liberty, Toole, Glacier, Pondera, Teton, Chouteau and Cascade Counties; Region 3: Judith Basin, Fergus, Petroleum, Musselshell, Gloden Valley, Wheatland, Sweetgrass, Stillwater, Yellowstone, Carbon and Big Horn Counties; Region 4: Lewis & Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater, Meagher, Park, Gallatin, Madison and Beaverhead Counties; Region 5: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula and Ravelli Counties."

Purpose of amendment 6: To assure that the recommendations of the Authority remain objective by prohibiting special interest amendments. This amendment would require the Legislature to vote up or down on each of the Authority's plans. One or both plans could then be returned to the Authority for further development.

6. Page 7, Section 4, line 20

Following: "concept."

Insert: "Both plans must be voted on by the 1995 Legislature no later than 45 days from the first day of the 1995 Legislative session. The Legislature may not amend either plan. The Legislature may return one or both plans to the Authority for further development."

Purpose of amendment 7: To assure that the health resource management plan is developed in conjunction with the Authority's recommendations for global budgeting and expenditure targets.

7. Page 9, Section 6, line 19

Following: "health resource management plan"

Insert: "which takes into account the provisions of Section 5."

Purpose of amendment 8: To assure that the authority has the power to enforce the health resource management plan. There is concern that language in Section 12 will prevent the authority's recommendations from being implemented simply if the provider or

facility disagrees with the recommendations. For example, the authority may recommended that a hospital not spend money to expand because the hospital served a community that already had too many beds. Language in Section 12 may prevent that recommendation from being enforced and should therefore be deleted. Otherwise, the health resource management plan will have no greater effect than Montana's current Certificate of Need program.

8. Page 17, Section 12, Line 24

Strike: "(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 corporate health care facility in a manner that usurps the appropriate powers of the board of directors of the facility."

Purpose of Amendment 9: To assure that the Authority has the financial resources and the clear mandate to collect the necessary data for establishing a global budget and a health resource management plan. It's inappropriate to transfer vital statistics to the Authority. A lot of data needs to be collected to enable the authority to set appropriate fee schedules and spending limits. There may be pressure on the Authority to focus on the collection of other types of data. According to the Governor of Vermont, Vermont encountered a similar problem. Governor Dean says that Vermont has spent the past 10 years collecting data, but much of it was not appropriate for developing spending limits. We need to make sure this does not happen in Montana.

9. Page 20, Section 14

Strike: All of Section 14

Purpose of Amendment 10: To make clear that the authority can delegate the employment of staff to the Executive Director. Otherwise it would seem that the authority would have to be a part of all the hiring. This amendment was recommended by Charles Aagenes.

10. Page 7, Section 3, Line 2

Following: "through 13]."

Insert: "The authority may delegate the duties described in (2) to the Executive Director."

2-18-93
SB-285

Purpose of Amendment 11: To allow the authority to contract with consultants. This amendment was recommended by Charles Aagenes.

11. Page 6, Section 3, Line 24

Following: "may employ"

Insert: "or contract with"

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 2-18-93
BILL NO. SB285

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

February 10, 1993
Wednesday

MONTANA MEDICAL ASSOCIATION SUGGESTED AMENDMENTS TO SB 285

1. Page 7, line 22.
   Following: "available"
   Insert: "a system of necessary and effective health care benefits."
   Strike: "a uniform system of health care benefits."

2. Page 7, line 25.
   Following: {Sections 5 through 8}.
   Add: "Nothing in this bill shall constrain Montana residents from seeking health care services not specifically delineated in the health care benefits package."

3. Page 8, line 15.
   Following: "shall"
   Insert: "most strongly consider"
   Strike: "include" on the same line

4. Page 9, line 1.
   Following: "items"
   Insert: "addressing the cost shifting caused by the current inadequacy of the Medicaid, Medicare, and other governmental pay systems"

5. Page 9, line 3.
   Following "provided"
   Insert: "utilizing a resource based relative value system"

See reverse, excerpt from Federal Register sample of relative value units.

SENATE HEALTH & WELFARE
EXHIBIT NO. 7
DATE 2-18-93
BILL NO SB285

for new draft

Amendments to Senate Bill 285, Introduced Copy
Proposed by the Montana Association of Life Underwriters
February 10,1993

1. Page 7, line 19. Page 9, Line3
Following: "concept"
Insert: ", a recommendation for a statewide universal access plan based on targeted reforms to the existing voluntary private - public partnership;"

2. Page 7, at the end of line 25. Page 10
Insert: "Each statewide plan must contain an actuarially sound estimate of the costs of implementing the plan through the year 2005."

3. Page 8, line 15.
Following: "shall"
Strike: "include"
Insert: "consider"

4. Page 8, line 20.
Following: "care"
Insert: ", including expanded utilization review and managed care methods"

5. Page 9, following line 4. Pg. 12 line 2
Insert: "(d) a system for reducing the use of defensive medicine by adopting practice protocols which would give providers guidelines to follow for specific procedures and impose limits on liability if the provider follows the guidelines in a manner not grossly negligent;
(e) a cost benefit analysis of mandated benefits and a recommendation to the next legislature to eliminate those it finds are not cost effective. For the purpose of this subsection, "mandated benefit" means state legislation that prescribes the content of disability insurance purchased from a health insurer. The term includes but is not limited to extended coverages for certain categories of individuals, covered benefits including mandated options and benefits limited to certain types of contracts, and coverages for freedom of choice practitioners;"
Renumber: subsequent subsections and correct internal references.

6. Page 9, line 14. Page 12 (h)
Following: "providers,"
Insert: "health insurers;"

7. Page 11, line 4.
Following: "billing;"
Insert: "and"

8. Page 11, line 8.
Following: "payors"
Strike: "; and"
Insert: "."

9. Page 11, following line 8.
Strike: subsection (c).
Insert: "(2) The commissioner of insurance may, after consulting with the authority, adopt administrative rules requiring health insurers to use uniform claims forms and standardized explanation of benefits."
Renumber: subsequent subsections.

10. Page 12, line 25. Page 17
Following: "providers"
Strike: "or"
Insert: ", payors including health insurers and"
Following: "consumers"
Strike: ;"or both";

11. Page 16, line 14. Page 25, line 3
Following: "protocols;"
Strike: "and"
Insert: "(d) compare costs of commonly performed health care procedures among providers and health care facilities within a region and make the data readily available to the public; and"
Renumber: subsequent subsections.

12. Page18, following line 3.
Strike: section 13 in its entirety.
Renumber: subsequent sections and amend effective date to conform.