HB 799 INTRODUCED BY LORY, ET AL.
REGULATE PREFERRED PROVIDER ARRANGEMENTS
BY REQUEST OF STATE AUDITOR

2/17 INTRODUCED
2/17 REFERRED TO BUSINESS & LABOR
2/19 HEARING
2/19 TABLED IN COMMITTEE

House BILL NO. 799

INTRODUCED BY Tony Meyer

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO THE REGULATION OF PREFERRED PROVIDER ARRANGEMENTS; PERMITTING INSURERS TO ENTER INTO ARRANGEMENTS WITH LICENSED HEALTH CARE PROVIDERS AND TO ISSUE POLICIES THAT INCLUDE INCENTIVES OR LIMIT REIMBURSEMENT FOR UTILIZING SERVICES RENDERED BY PROVIDERS WITH WHOM THE INSURER HAS AN ARRANGEMENT; AMENDING SECTION 33-22-111, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

NEW SECTION. Section 1. Short title. [Sections 1 through 12] may be cited as the "Preferred Provider Arrangements Act".

NEW SECTION. Section 2. Purpose. The purpose of [sections 1 through 12] is to allow health care insurers providing group disability insurance benefits to negotiate and contract with licensed health care providers either to provide health care services to its subscribers at a reduction in the fees customarily charged by the provider or to enter into arrangements whereby the participating providers accept negotiated fees as payment in full for

covered services.

NEW SECTION. Section 3. Definitions. As used in [sections 1 through 12], the following definitions apply:

(1) "Covered services" means health care services that the health care insurer is obligated to pay for or provide under the health benefit plan.

(2) "Emergency services" means services provided in case of a sudden, serious, and unexpected illness or injury that requires immediate medical attention.

(3) "Health benefit plan" means the health insurance policy or subscriber arrangement between the insured or subscriber and the health care insurer that defines the covered services and benefit levels available.

(4) "Health care insurer" means an insurer that provides disability insurance as defined in 33-1-207, a health service corporation as defined in 33-30-101, a health maintenance organization [as defined in section 1 of __ Bill No. __ [LC 1134]], a fraternal benefit society as defined in 33-7-102, or any other entity regulated by the insurance department that provides group health coverage.

(5) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization. The term includes but is not limited to hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

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(6) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

(8) "Preferred provider arrangement" means a contract between or on behalf of a health care insurer and a preferred provider.

(9) "Provider" means an individual or entity licensed or authorized to provide health care services in this state.

(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is paying for or providing health care coverage.

NEW SECTION. Section 4. Preferred provider arrangements authorized. (1) Notwithstanding any provision of law to the contrary, a health care insurer may:

(a) enter into arrangements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is paying for or providing health care coverage, including preferred provider arrangements relating to:

(i) the amount and manner of payment to the provider; and

(ii) the review and control of utilization of health care services, if those arrangements do not result in imposition of costs on policyholders or subscribers by reason of postutilization denial of payment for services over which those policyholders or subscribers have no control; and

(b) issue or administer policies or subscriber contracts in this state that include incentives for the insured to utilize the services of a provider that has entered into an arrangement with the health care insurer pursuant to subsection (1)(a).

(2) A preferred provider arrangement issued or delivered in this state must:

(a) establish the amount and manner of payment to the preferred provider. The amount and manner of payment may include per capita payments to the preferred provider.

(b) include mechanisms that are designed to minimize the cost of the health benefit plan. These mechanisms may include among others:

(i) review or control of utilization of health care services; and

(ii) a procedure for determining whether health care services rendered are medically necessary;

(c) assure reasonable access to covered services available under the preferred provider arrangement and an

adequate number of preferred providers to render those services.

(3) A preferred provider arrangement issued or delivered in this state may not unfairly deny health benefits for medically necessary covered services.

(4) Nothing in {sections 1 through 12} may be interpreted to require that an insurer negotiate or enter into arrangements with a specific provider or class of providers.

NEW SECTION. Section 5. Incentives in health benefit plans. (1) A health care insurer may issue a policy or a health benefit plan that provides for incentives for covered persons to use the health care services of preferred providers. The policy or health benefit plan must contain at least the following:

(a) a provision that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot reasonably reach a preferred provider, the care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider; and

(b) a provision that clearly identifies the differentials in benefit levels for health care services of a preferred provider and benefit levels for health care services of nonpreferred providers.

(2) If the policy or health benefit plan provides differences in benefit levels payable to a preferred provider compared to other providers, the differences may not unfairly deny payment for covered services and may be no greater than necessary to provide a reasonable incentive for covered persons to use the preferred provider.

NEW SECTION. Section 6. Reimbursement for emergency services. If a subscriber receives emergency services and cannot reasonably reach a preferred provider, the emergency services must be reimbursed as though the subscriber had been treated by a preferred provider.

NEW SECTION. Section 7. Permissible provisions in provider arrangements, insurance policies, and subscriber contracts. (1) A provider arrangement, insurance policy, or subscriber contract issued or delivered in this state may contain other components designed to control the cost and improve the quality of health care for policyholders and subscribers, including:

(a) per capita payment to providers;

(b) a payment differential of not more than 25% between use of providers with arrangements with the health care insurer and use of providers without such arrangements. The commissioner may by rule determine appropriate differentials between copayments, deductibles, or other cost-sharing arrangements.

(c) limitations on the number of providers with whom arrangements may be made following satisfaction of the basic standards set forth by the health care insurer, except that there may be no discrimination against any class of providers and no discrimination on the basis of religion, race, color, national origin, age, sex, or marital status;

(d) conditions, not inconsistent with other provisions of [sections 1 through 12], designed to give incentive to policyholders or subscribers to choose a particular provider; and

(e) other provisions not inconsistent with [sections 1 through 12] that the commissioner may approve.

(2) All terms or conditions of a provider arrangement, insurance policy, or subscriber contract are subject to the prior approval of the commissioner.

NEW SECTION. Section 8. Arrangements with providers. (1) Notwithstanding any other provision of law to the contrary, a person doing business in this state, including but not limited to a provider, health care insurer, insurance agent, or third-party administrator, may make arrangements with providers as authorized in [section 4] and may make such arrangements available to health care insurers only if, in performing such functions, the person:

(a) does not accept financial risk of loss and is reimbursed solely for his functions of entering arrangements

and marketing and administering those arrangements; and

(b) adequately discloses his role and limited responsibilities whenever making those arrangements available to health care insurers, insureds, or subscribers.

(2) A person described in subsection (1) shall file with the commissioner a sworn certification affirming that he has complied with the requirements of this section and providing a concise description of his operations. If a material change in operations occurs, the person shall refile the sworn certification.

NEW SECTION. Section 9. Applicability -- filing with commissioner. (1) Within 60 days of [the effective date of sections 1 through 12], a person or organization performing the functions enumerated in [sections 4 through 7] shall notify the commissioner of its existence, provide the commissioner with the information the commissioner may determine to be necessary, and continue to operate subject to applicable laws.

(2) A person performing the functions enumerated in [section 8] and operating prior to [the effective date of sections 1 through 12] shall file a certification as required in [section 8] within 60 days of [the effective date of sections 1 through 12]. Any person who commences performance of the functions enumerated in [section 8] after [the effective date of sections 1 through 12] shall file the

certification within 30 days of commencement.

NEW SECTION. Section 10. Jurisdiction of commissioner. A person or other entity that provides coverage in this state for services of providers, whether this coverage is by direct payment, reimbursement, or otherwise, and that enters any arrangement of the type set forth in [sections 1 through 12] or underwrites using preferred provider arrangements set forth in [sections 1 through 12] is subject to the jurisdiction of the commissioner.

NEW SECTION. Section 11. Rules. The commissioner may make reasonable rules relating to the accessibility and availability of health care services for persons insured under policies or contracts described in [section 4].

NEW SECTION. Section 12. Penalty. The commissioner may impose the penalties provided in 33-1-104 and 33-1-317 for any violation of [sections 1 through 12].

Section 13. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) ~~All~~ Except as provided in [sections 1 through 12], all policies of disability insurance, including individual, group, and blanket policies, and all policies insuring the payment of compensation under the Workers' Compensation Act

shall provide that the insured shall have full freedom of choice in the selection of any duly licensed physician, dentist, osteopath, chiropractor, optometrist, chiropodist, psychologist, licensed social worker, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of his practice. Whenever such policies insure against the expense of drugs, the insured shall have full freedom of choice in the selection of any duly licensed and registered pharmacist. An insurer shall offer, at additional cost to the insured, the option of disability and health insurance coverage for services performed by a licensed professional counselor.

(2) Nothing in this section shall be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated . subsection (1); nor shall this section be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

NEW SECTION. Section 14. Codification instruction. Sections 1 through 12 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through 12.

NEW SECTION. Section 15. Coordination instruction. If __ Bill No. __ [LC 1134], including the definition of "health maintenance organization" is not passed and

approved, the bracketed language in subsection (4) of section 3 of this act is void.

NEW SECTION. Section 16. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 17. Effective date. This act is effective on passage and approval.

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