SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

IN THE SENATE

FEBRUARY 18, 1987	INTRODUCED AND REFERRED TO COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY.
FEBRUARY 21, 1987	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
	STATEMENT OF INTENT ADOPTED.
FEBRUARY 23, 1987	PRINTING REPORT.
FEBRUARY 24, 1987	SECOND READING, DO PASS.
FEBRUARY 25, 1987	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 50; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

MARCH 3, 1987	INTRODUCED AND REFERRED TO COMMITTEE ON HUMAN SERVICES & AGING.
MARCH 13, 1987	ON MOTION, REREFERRED TO COMMITTEE ON BUSINESS & LABOR.
MARCH 27, 1987	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
MARCH 28, 1987	SECOND READING, CONCURRED IN.
MARCH 30, 1987	THIRD READING, CONCURRED IN. AYES, 92; NOES, 6.
	RETURNED TO SENATE WITH AMENDMENTS.

	IN THE SENATE
APRIL 2, 1987	RECEIVED FROM HOUSE.
	ON MOTION, CONSIDERATION PASSED FOR THE DAY.
APRIL 3, 1987	SECOND READING, AMENDMENTS NOT CONCURRED IN.
APRIL 6, 1987	ON MOTION, CONFERENCE COMMITTEE REQUESTED AND APPOINTED.
	IN THE HOUSE
APRIL 14, 1987	ON MOTION, CONFERENCE COMMITTEE REQUESTED AND APPOINTED.
	IN THE SENATE
APRIL 15, 1987	CONFERENCE COMMITTEE REPORTED.
APRIL 16, 1987	SECOND READING, CONFERENCE COMMITTEE REPORT ADOPTED.
APRIL 17, 1987	THIRD READING, CONFERENCE COMMITTEE REPORT ADOPTED.
	IN THE HOUSE
APRIL 17, 1987	CONFERENCE COMMITTEE REPORT ADOPTED.
	IN THE SENATE
APRIL 23, 1987	SENT TO ENROLLING.

LC 1390/01

INTRODUCED BY [signature] BILL NO. 371

A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH 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 AGREEMENT; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Short title. [Sections 1 through 4] may be cited as the "Health Care Reimbursement Reform Act".

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

(1) "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, including but not limited to hospital, medical, surgical, dental, vision, and pharmaceutical services and products.

(2) "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.

(3) "Insurer" means an insurance company or a health service corporation authorized in this state to issue policies or subscriber contracts that reimburse an insured for expenses of health care services.

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

Section 3. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, an insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to the insurer's insureds, including agreements relating to the amounts an insured may be charged for services rendered; and

(b) issue or administer policies or subscriber contracts in this state that:

(i) include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a); or

(ii) provide for reimbursement for health care services only if the services are rendered by a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).

(2) [Sections 1 through 4] do not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.

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Section 4. Rules. The commissioner shall promulgate rules prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies or contracts described in [section 3(1)(b)(ii)].

Section 5. Codification instruction. Sections 1 through 4 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through 4.

Section 6. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 7. Effective date. This act is effective on passage and approval.

-End-

APPROVED BY COMMITTEE
ON PUBLIC HEALTH, WELFARE
& SAFETY

STATEMENT OF INTENT

SENATE BILL 371

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because section 6 authorizes the commissioner of insurance to promulgate rules prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies or contracts described in section 3. The legislature intends that the rules adopted to implement this bill be designed to:

(1) foster accessibility and availability of health care services; and

(2) protect Montana health care insurance consumers.

The legislature further intends that the commissioner adopt rules to implement this act in accordance with 33-1-313, which permits the commissioner:

(1) to make only reasonable rules that do not extend, modify, or conflict with any law of this state or with any reasonable implication of such law; and

(2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

SECOND READING
SB 371

SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH 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 AGREEMENT; AND PROVIDING AN ~~IMMEDIATE~~ EFFECTIVE DATE."

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

Section 1. Short title. [Sections 1 through ~~4~~ 6] may be cited as the "Health Care Reimbursement Reform Act".

Section 2. Definitions. As used in [sections 1 through ~~4~~ 6], the following definitions apply:

(1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD REASONABLY EXPECT THAT:

(A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(2) "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.

~~(1)~~(3) "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, including but not limited to hospital, medical, surgical, dental, vision, and pharmaceutical services and products.

~~(2)~~(4) "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.

~~(3)~~(5) "Insurer" means an insurance company or a health service corporation authorized in this state to issue policies or subscriber contracts that reimburse an insured for expenses of health care services.

~~(4)~~(6) "Provider" means an individual or entity licensed or legally authorized to provide health care services in this state.

Section 3. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, an insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to the insurer's

insureds, including agreements relating to the amounts an insured may be charged for services rendered; and

(b) issue or administer policies or subscriber contracts in this state that:

~~(i)~~ include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a)~~;~~ ~~or~~.

~~(ii) provide for reimbursement for health care services only if the services are rendered by a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a);~~

(2) A PREFERRED PROVIDER ARRANGEMENT ISSUED OR DELIVERED IN THIS STATE MAY NOT UNFAIRLY DENY HEALTH BENEFITS FOR MEDICALLY NECESSARY COVERED EXPENSES.

~~(2)~~(3) [Sections 1 through 4 6] do not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.

SECTION 4. 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.

(2) THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT LEAST 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.

SECTION 5. 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 CERTAIN OTHER COMPONENTS DESIGNED TO CONTROL THE COST AND IMPROVE THE QUALITY OF HEALTH CARE FOR POLICYHOLDERS AND SUBSCRIBERS, INCLUDING:

(A) 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, AND OTHER COST-SHARING ARRANGEMENTS.

(B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS OF [SECTIONS 1 THROUGH 6], DESIGNED TO GIVE POLICYHOLDERS OR SUBSCRIBERS AN INCENTIVE TO CHOOSE A PARTICULAR PROVIDER.

(2) ALL TERMS OR CONDITIONS OF A PROVIDER ARRANGEMENT, INSURANCE POLICY, OR SUBSCRIBER CONTRACT ARE SUBJECT TO THE PRIOR APPROVAL OF THE COMMISSIONER.

Section 6. Rules. The commissioner shall promulgate rules prescribing reasonable standards relating to the accessibility and availability of health care services for

persons insured under policies or contracts described in [~~section 3(1)(b)(ii)~~ SECTIONS 1 THROUGH 6].

Section 7. Codification instruction. Sections 1 through ~~4~~ 6 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through ~~4~~ 6.

Section 8. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 9. Effective date. ~~This act is~~ SECTION 6 AND THIS SECTION ARE effective on passage and approval.

-End-

STATEMENT OF INTENT

SENATE BILL 371

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because section 6 authorizes the commissioner of insurance to promulgate rules prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies or contracts described in section 3. The legislature intends that the rules adopted to implement this bill be designed to:

(1) foster accessibility and availability of health care services; and

(2) protect Montana health care insurance consumers.

The legislature further intends that the commissioner adopt rules to implement this act in accordance with 33-1-313, which permits the commissioner:

(1) to make only reasonable rules that do not extend, modify, or conflict with any law of this state or with any reasonable implication of such law; and

(2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

THIRD READING

SB 371

SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH 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 AGREEMENT; AND PROVIDING AN ~~IMMEDIATE~~ EFFECTIVE DATE."

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

Section 1. Short title. [Sections 1 through 4 6] may be cited as the "Health Care Reimbursement Reform Act".

Section 2. Definitions. As used in [sections 1 through 4 6], the following definitions apply:

(1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD REASONABLY EXPECT THAT:

(A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(2) "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.

~~(1)~~(3) "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, including but not limited to hospital, medical, surgical, dental, vision, and pharmaceutical services and products.

~~(2)~~(4) "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.

~~(3)~~(5) "Insurer" means an insurance company or a health service corporation authorized in this state to issue policies or subscriber contracts that reimburse an insured for expenses of health care services.

~~(4)~~(6) "Provider" means an individual or entity licensed or legally authorized to provide health care services in this state.

Section 3. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, an insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to the insurer's

insureds, including agreements relating to the amounts an insured may be charged for services rendered; and

(b) issue or administer policies or subscriber contracts in this state that~~:~~

~~(i)~~ include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a)~~;~~ ~~or~~.

~~(ii) provide for reimbursement for health care services only if the services are rendered by a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a);~~

(2) A PREFERRED PROVIDER ARRANGEMENT ISSUED OR DELIVERED IN THIS STATE MAY NOT UNFAIRLY DENY HEALTH BENEFITS FOR MEDICALLY NECESSARY COVERED EXPENSES.

~~(2)~~(3) [Sections 1 through ~~4~~ 6] do not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.

SECTION 4. 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.

(2) THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT LEAST 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.

SECTION 5. 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 CERTAIN OTHER COMPONENTS DESIGNED TO CONTROL THE COST AND IMPROVE THE QUALITY OF HEALTH CARE FOR POLICYHOLDERS AND SUBSCRIBERS, INCLUDING:

(A) 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, AND OTHER COST-SHARING ARRANGEMENTS.

(B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS OF [SECTIONS 1 THROUGH 6], DESIGNED TO GIVE POLICYHOLDERS OR SUBSCRIBERS AN INCENTIVE TO CHOOSE A PARTICULAR PROVIDER.

(2) ALL TERMS OR CONDITIONS OF A PROVIDER ARRANGEMENT, INSURANCE POLICY, OR SUBSCRIBER CONTRACT ARE SUBJECT TO THE PRIOR APPROVAL OF THE COMMISSIONER.

Section 6. Rules. The commissioner shall promulgate rules prescribing reasonable standards relating to the accessibility and availability of health care services for

persons insured under policies or contracts described in [~~section-3(1)(b)(ii)~~ SECTIONS 1 THROUGH 6].

Section 7. Codification instruction. Sections 1 through ~~4~~ 6 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through ~~4~~ 6.

Section 8. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 9. Effective date. ~~This act is~~ SECTION 6 AND THIS SECTION ARE effective on passage and approval.

-End-

STATEMENT OF INTENT

SENATE BILL 371

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because section 6 authorizes the commissioner of insurance to promulgate rules prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies or contracts described in section 3. The legislature intends that the rules adopted to implement this bill be designed to:

(1) foster accessibility and availability of health care services; and

(2) protect Montana health care insurance consumers.

The legislature further intends that the commissioner adopt rules to implement this act in accordance with 33-1-313, which permits the commissioner:

(1) to make only reasonable rules that do not extend, modify, or conflict with any law of this state or with any reasonable implication of such law; and

(2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

REFERENCE BILL
SB 371

SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH 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 AGREEMENT; AND PROVIDING AN ~~IMMEDIATE~~ APPLICABILITY DATE AND AN EFFECTIVE DATE."

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

Section 1. Short title. [Sections 1 through 4 6 7] may be cited as the "~~Health-Care-Reimbursement-Reform~~ PREFERRED PROVIDER AGREEMENTS Act".

SECTION 2. PURPOSE. THE PURPOSE OF [SECTIONS 1 THROUGH 7] IS TO ALLOW A HEALTH CARE INSURER PROVIDING DISABILITY INSURANCE BENEFITS TO NEGOTIATE AND CONTRACT WITH HEALTH CARE PROVIDERS TO:

(1) PROVIDE HEALTH CARE SERVICES TO ITS INSUREDS OR SUBSCRIBERS AT A REDUCTION IN THE FEES CUSTOMARILY CHARGED BY THE PROVIDER; OR

(2) ENTER INTO AGREEMENTS IN WHICH THE PARTICIPATING PROVIDERS ACCEPT NEGOTIATED FEES AS PAYMENT IN FULL FOR HEALTH CARE SERVICES THE HEALTH CARE INSURER IS OBLIGATED TO PROVIDE OR PAY FOR UNDER THE HEALTH BENEFIT PLAN.

Section 3. Definitions. As used in [sections 1 through 4 6 7], the following definitions apply:

(1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD REASONABLY EXPECT THAT:

(A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(2) "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.

(3) "HEALTH CARE INSURER" MEANS:

(A) AN INSURER THAT PROVIDES DISABILITY INSURANCE AS DEFINED IN 33-1-207;

(B) A HEALTH SERVICE CORPORATION AS DEFINED IN 33-30-101;

(C) A HEALTH MAINTENANCE ORGANIZATION [AS DEFINED IN SECTION 2 OF SENATE BILL NO. 353];

(D) A FRATERNAL BENEFIT SOCIETY AS DEFINED IN 33-7-102;

(E) AN ADMINISTRATOR AS DEFINED IN 33-17-601; OR

(F) ANY OTHER ENTITY REGULATED BY THE COMMISSIONER THAT PROVIDES HEALTH COVERAGE.

~~(2)~~(3)(4) "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~~, including but not limited to hospital, medical, surgical, dental, vision, and pharmaceutical services and products~~ OR SERVICES PROVIDED UNDER TITLE 33, CHAPTER 22, PART 7.

~~(3)~~(4)(5) "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.

~~(5) "Insurer" means an insurance company or a health service corporation authorized in this state to issue policies or subscriber contracts that reimburse an insured for expenses of health care services.~~

(6) "PREFERRED PROVIDER" MEANS A PROVIDER OR GROUP OF PROVIDERS WHO HAVE CONTRACTED TO PROVIDE SPECIFIED HEALTH CARE SERVICES.

(7) "PREFERRED PROVIDER AGREEMENT" MEANS A CONTRACT BETWEEN OR ON BEHALF OF A HEALTH CARE INSURER AND A PREFERRED PROVIDER.

~~(4)~~(6)(8) "Provider" means an individual or entity licensed or legally authorized to provide health care

services ~~in this state~~ OR SERVICES COVERED WITHIN TITLE 33, CHAPTER 22, PART 7.

(9) "SUBSCRIBER" MEANS A CERTIFICATE HOLDER OR OTHER PERSON ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING OR PAYING FOR HEALTH CARE COVERAGE.

Section 4. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, ~~an~~ A HEALTH CARE insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to ~~the insurer's~~ insureds OR SUBSCRIBERS ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING HEALTH CARE COVERAGE, including PREFERRED PROVIDER agreements relating to:

(I) the amounts an insured may be charged for services rendered; AND

(II) THE AMOUNT AND MANNER OF PAYMENT TO THE PROVIDER; and

(b) issue or administer policies or subscriber contracts in this state that:

~~(i)~~ include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a)~~;~~ or.

~~(ii) provide for reimbursement for health care services only if the services are rendered by a provider that has entered into an agreement with the insurer pursuant to~~

~~subsection (1)(a),~~

(2) A PREFERRED PROVIDER ~~ARRANGEMENT~~ AGREEMENT ISSUED OR DELIVERED IN THIS STATE MAY NOT UNFAIRLY DENY HEALTH BENEFITS FOR ~~MEDICALLY--NECESSARY~~ HEALTH CARE SERVICES COVERED ~~EXPENSES~~.

~~(2)~~(3) [Sections 1 through ~~4~~ 6 7] do not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.

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.

~~(2)~~ THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT LEAST:

(A) A PROVISION THAT IF A COVERED PERSON RECEIVES EMERGENCY CARE FOR SERVICES SPECIFIED IN THE PREFERRED PROVIDER ~~ARRANGEMENT~~ AGREEMENT 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 DIFFERENCE IN BENEFIT LEVELS FOR HEALTH CARE SERVICES OF A PREFERRED PROVIDER AND BENEFIT LEVELS FOR THE SAME HEALTH CARE SERVICES OF A NONPREFERRED PROVIDER.

(2) A HEALTH CARE INSURER MAY NOT REQUIRE HOSPITAL

STAFF PRIVILEGES AS CRITERIA FOR DESIGNATION AS A PREFERRED PROVIDER IN A PREFERRED PROVIDER AGREEMENT.

SECTION 6. PERMISSIBLE PROVISIONS IN PROVIDER ~~ARRANGEMENTS~~ AGREEMENTS, INSURANCE POLICIES, AND SUBSCRIBER CONTRACTS. (1) A PROVIDER ~~ARRANGEMENT~~ AGREEMENT, INSURANCE POLICY, OR SUBSCRIBER CONTRACT ISSUED OR DELIVERED IN THIS STATE MAY CONTAIN CERTAIN OTHER COMPONENTS DESIGNED TO CONTROL THE COST AND IMPROVE THE QUALITY OF HEALTH CARE FOR ~~POLICYHOLDERS~~ INSUREDS AND SUBSCRIBERS, INCLUDING:

(A) 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,--AND--OTHER COST-SHARING---ARRANGEMENTS~~ PROVISION SETTING A PAYMENT DIFFERENCE FOR REIMBURSEMENT OF A NONPREFERRED PROVIDER AS COMPARED TO A PREFERRED PROVIDER. IF THE HEALTH BENEFIT PLAN CONTAINS A PAYMENT DIFFERENCE PROVISION, THE PAYMENT DIFFERENCE MAY NOT EXCEED 25% OF THE REIMBURSEMENT LEVEL AT WHICH A PREFERRED PROVIDER WOULD BE REIMBURSED.

(B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS OF [SECTIONS 1 THROUGH 6], DESIGNED TO GIVE POLICYHOLDERS OR SUBSCRIBERS AN INCENTIVE TO CHOOSE A PARTICULAR PROVIDER.

(2) ALL TERMS OR CONDITIONS OF ~~A PROVIDER ARRANGEMENT,~~ AN INSURANCE POLICY, OR SUBSCRIBER CONTRACT, EXCEPT THOSE

ALREADY APPROVED BY THE COMMISSIONER, ARE SUBJECT TO THE PRIOR APPROVAL OF THE COMMISSIONER.

Section 7. Rules. The commissioner shall promulgate rules ~~prescribing--reasonable--standards--relating--to--the accessibility--and--availability-of-health-care-services-for persons-insured-under-policies--or--contracts--described--in~~ NECESSARY TO IMPLEMENT THE PROVISIONS OF ~~[section 3(1)(b)(iii)~~ SECTIONS 1 THROUGH 6 7].

Section 8. Codification instruction. Sections 1 through ~~4~~ 6 7 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through ~~4~~ 6 7.

SECTION 9. COORDINATION INSTRUCTION. IF SENATE BILL NO. 353, INCLUDING THE DEFINITION OF "HEALTH MAINTENANCE ORGANIZATION", IS NOT PASSED AND APPROVED, THE BRACKETED LANGUAGE IN SECTION 3(3)(C) OF THIS ACT IS VOID.

Section 10. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

SECTION 11. APPLICABILITY -- FILING WITH COMMISSIONER. ON OR BEFORE JANUARY 1, 1988, A HEALTH CARE INSURER PERFORMING THE FUNCTIONS ENUMERATED IN THIS ACT SHALL NOTIFY

THE COMMISSIONER OF ITS EXISTENCE AND CONTINUE TO OPERATE SUBJECT TO THE PROVISIONS OF THIS ACT.

Section 12. Effective date. ~~This-act-is~~ SECTION 6 7 AND THIS SECTION ARE effective on passage and approval.

-End-

SB371.CCR

CONFERENCE COMMITTEE REPORT

Report No. 1

April 14, 1987

MR. PRESIDENT

We, your _____ Conference Committee on

SENATE BILL 371

met and considered House Business and Labor Standing Committee

amendments to Senate Bill 371, dated March 26, 1987.

We recommend as follows:

THAT SENATE BILL 371, reference copy salmon, BE AMENDED AS FOLLOWS:

1. Page 6, line 20.
Following: " REIMBURSED. "
Insert: "The commissioner shall review differences between copayments, deductibles, and other cost-sharing arrangements."

And that this Conference Committee report be adopted.

FOR THE SENATE

REGAN, CHAIRPERSON

BENGTSON

HARDING

ADOPT REJECT

FOR THE HOUSE

KITSELMAN

THOMAS

J. BROWN

STANDING COMMITTEE REPORT

HOUSE

MARCH 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 371

☐ do pass ☒ be concurred in ☒ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Title, line 8
Following: "PROVIDING AN"
Insert: "APPLICABILITY DATE AND AN"

2) Page 1, line 12
Strike: "6"
Insert: "7"

3) Page 1, line 13
Strike: "Health Care Reimbursement Reform"
Insert: "Preferred Provider Agreements"

4) Page 1, line 14
Following: line 13
Insert: "Section 2. Purpose. The purpose of [sections 1 through 7] is to allow a health care insurer providing disability insurance benefits to negotiate and contract with health care providers to: (1) provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider; or (2) enter into agreements in which the participating providers accept negotiated fees as payment in full for health care services the health care insurer is obligated to provide or pay for under the health benefit plan."
Renumber: subsequent sections

5) Page 1, line 15
Strike: "6"
Insert: "7"

6) Page 2, line 5
Following: line 4
Insert: "(3)" Health care insurer" means:
(a) an insurer that provides disability insurance as defined in 33-1-207;
(b) a health service corporation as defined in 33-30-101;

THIRD reading copy (BLUE color)

REP. KITSELMAN will sponsor

(c) a health maintenance organization [as defined in section 2 of Senate Bill no. 353];
(d) a fraternal, benefit society as defined in 33-7-102;
(e) an administrator as defined in 33-17-601; or
(f) any other entity regulated by the commissioner that provides health coverage."
Renumber: subsequent subsections

7) Page 2, lines 7 through 9
Following: "authorization" on line 7
Strike: the remainder of line 7, line 8 in its entirety, and line 9 through "products"
Insert: "or services provided under Title 33, chapter 22, part 7"

8) Page 2, lines 14 through 17
Strike: subsection (5) in its entirety
Insert: "(6) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.
(7) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider."
Renumber: subsequent subsection

9) Page 2, line 20
Strike: "in this state"
Insert: "or services covered within Title 33, chapter 22, part 7"

10) Page 2, line 21
Following: line 20
Insert: "(9) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

11) Page 2, line 23
Strike: "an"
Insert: "a health care"

12) Page 2, line 25
Strike: "the insurer's"

Chairman.

13) Page 3, line 1
Following: "insureds"
Insert: "or subscribers on whose behalf the health care insurer is providing health care coverage"
Following: "including"
Insert: "preferred provider"
Following: "to"
Insert: ": (i)"

14) Page 3, line 2
Following: ";"
Insert: "and (ii) the amount and manner of payment to the provider;"

15) Page 3, line 12
Strike: "ARRANGEMENT"
Insert: "agreement"

16) Page 3, line 14
Strike: "MEDICALLY NECESSARY"
Insert: "health care services"
Strike: "EXPENSES"

17) Page 3, line 15
Strike: "6"
Insert: "7"

18) Page 3, line 22
Strike: "(2)"

19) Page 3, line 23
Following: "LEAST"
Insert: ": (a)"

20) Page 3, line 25
Strike: "ARRANGEMENT"
Insert: "agreement"

21) Page 4, line 3
Following: "PROVIDER"
Insert: "; and
(b) a provision that clearly identifies the difference in benefit levels for health care services of a preferred provider and benefit levels for the same health care services of a nonpreferred provider"

Chairman.

22) Page 4, line 4
Following: line 3
Insert: (2) A health care insurer may not require hospital staff privileges as criteria for designation as a preferred provider in a preferred provider agreement."

23) Page 4, line 5
Strike: "ARRANGEMENTS"
Insert: "agreements"

24) Page 4, line 6
Strike: "ARRANGEMENT"
Insert: "agreement"

25) Page 4, line 9
Strike: "POLICYHOLDERS"
Insert: "insureds"

26) Page 4, lines 11 through 16
Following: "(A) A" on line 11
Strike: the remainder of line 11, lines 12 through 15 in their entirety and line 16 through "ARRANGEMENTS"
Insert: "provision setting a payment difference for reimbursement of a nonpreferred provider as compared to a preferred provider. If the health benefit plan contains a payment difference provision, the payment difference may not exceed 25% of the reimbursement level at which a preferred provider would be reimbursed"

27) Page 4, line 20
Following: "OF"
Strike: " A PROVIDER ARRANGEMENT,"
Insert: "an"

28) Page 4, line 21
Following: "POLICY"
Strike: ","
Following: "CONTRACT"
Insert: "except those already approved by the commissioner,"

29) Page 4, line 24, through page 5, line 1
Following: "rules" on line 24
Strike: the remainder of line 24, lines 25 and 1 in their entirety
Insert: "necessary to implement the provisions of"

Chairman.

30) Page 5, line 2
Strike: "6"
Insert: "7"

31) Page 5, line 4
Strike: "6"
Insert: "7"

32) Page 5, line 6
Strike: "6"
Insert: "7"

33) Page 5, line 7
Following: line 6
Insert: "Section 9. Coordination instruction. If Senate Bill No. 353, including the definition of "health maintenance organization", is not passed and approved, the bracketed language in section 3(3)(c) of this act is void."
Renumber: subsequent sections

34) Page 5, line 13
Following: line 12
Insert: "Section 11. Applicability -- filing with commissioner. On or before January 1, 1988, a health care insurer performing the functions enumerated in this act shall notify the commissioner of its existence and continue to operate subject to the provisions of this act."
Renumber: subsequent section

35) Page 5, line 13
Strike: "6"
Insert: "7"

Chairman.

STATEMENT OF INTENT

SENATE BILL 371

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because section 6 authorizes the commissioner of insurance to promulgate rules prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies or contracts described in section 3. The legislature intends that the rules adopted to implement this bill be designed to:

(1) foster accessibility and availability of health care services; and

(2) protect Montana health care insurance consumers.

The legislature further intends that the commissioner adopt rules to implement this act in accordance with 33-1-313, which permits the commissioner:

(1) to make only reasonable rules that do not extend, modify, or conflict with any law of this state or with any reasonable implication of such law; and

(2) to make or amend those rules only after a hearing of which notice has been given as required by 33-1-703.

REFERENCE BILL: Includes Conference Committee report
Dated 4-17-87

SB 371

SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH 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 AGREEMENT; AND PROVIDING AN ~~IMMEDIATE~~ APPLICABILITY DATE AND AN EFFECTIVE DATE."

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

Section 1. Short title. [Sections 1 through ~~4~~ 6 7] may be cited as the "~~Health Care Reimbursement Reform~~ PREFERRED PROVIDER AGREEMENTS Act".

SECTION 2. PURPOSE. THE PURPOSE OF [SECTIONS 1 THROUGH 7] IS TO ALLOW A HEALTH CARE INSURER PROVIDING DISABILITY INSURANCE BENEFITS TO NEGOTIATE AND CONTRACT WITH HEALTH CARE PROVIDERS TO:

(1) PROVIDE HEALTH CARE SERVICES TO ITS INSUREDS OR SUBSCRIBERS AT A REDUCTION IN THE FEES CUSTOMARILY CHARGED BY THE PROVIDER; OR

(2) ENTER INTO AGREEMENTS IN WHICH THE PARTICIPATING PROVIDERS ACCEPT NEGOTIATED FEES AS PAYMENT IN FULL FOR HEALTH CARE SERVICES THE HEALTH CARE INSURER IS OBLIGATED TO PROVIDE OR PAY FOR UNDER THE HEALTH BENEFIT PLAN.

Section 3. Definitions. As used in [sections 1 through ~~4~~ 6 7], the following definitions apply:

(1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD REASONABLY EXPECT THAT:

(A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(2) "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.

(3) "HEALTH CARE INSURER" MEANS:

(A) AN INSURER THAT PROVIDES DISABILITY INSURANCE AS DEFINED IN 33-1-207;

(B) A HEALTH SERVICE CORPORATION AS DEFINED IN 33-30-101;

(C) A HEALTH MAINTENANCE ORGANIZATION [AS DEFINED IN SECTION 2 OF SENATE BILL NO. 353];

(D) A FRATERNAL BENEFIT SOCIETY AS DEFINED IN 33-7-102;

(E) AN ADMINISTRATOR AS DEFINED IN 33-17-601; OR

(F) ANY OTHER ENTITY REGULATED BY THE COMMISSIONER THAT PROVIDES HEALTH COVERAGE.

~~(1)~~(3)(4) "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~~, including--but--not--limited-to-hospital,-medical,-surgical,-dental,-vision,-and-pharmaceutical-services-and-products~~ OR SERVICES PROVIDED UNDER TITLE 33, CHAPTER 22, PART 7.

~~(2)~~(4)(5) "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.

~~(3)(5)--"Insurer"--means--an--insurance--company--or--a health-service-corporation-authorized-in-this-state-to-issue policies--or--subscriber-contracts-that-reimburse-an-insured for-expenses-of-health-care-services.~~

(6) "PREFERRED PROVIDER" MEANS A PROVIDER OR GROUP OF PROVIDERS WHO HAVE CONTRACTED TO PROVIDE SPECIFIED HEALTH CARE SERVICES.

(7) "PREFERRED PROVIDER AGREEMENT" MEANS A CONTRACT BETWEEN OR ON BEHALF OF A HEALTH CARE INSURER AND A PREFERRED PROVIDER.

~~(4)~~(6)(8) "Provider" means an individual or entity licensed or legally authorized to provide health care

services ~~in-this-state~~ OR SERVICES COVERED WITHIN TITLE 33, CHAPTER 22, PART 7.

(9) "SUBSCRIBER" MEANS A CERTIFICATE HOLDER OR OTHER PERSON ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING OR PAYING FOR HEALTH CARE COVERAGE.

Section 4. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, ~~an~~ A HEALTH CARE insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to ~~the--insurer's~~ insureds OR SUBSCRIBERS ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING HEALTH CARE COVERAGE, including PREFERRED PROVIDER agreements relating to:

(I) the amounts an insured may be charged for services rendered; AND

(II) THE AMOUNT AND MANNER OF PAYMENT TO THE PROVIDER; and

(b) issue or administer policies or subscriber contracts in this state that:

~~(i)~~ include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a)~~,~~ or.

~~(ii)-provide-for-reimbursement-for-health-care-services only--if--the--services--are-rendered-by-a-provider-that-has entered-into-an--agreement--with--the--insurer--pursuant--to~~

~~subsection (1)(a).~~

(2) A PREFERRED PROVIDER ~~ARRANGEMENT~~ AGREEMENT ISSUED OR DELIVERED IN THIS STATE MAY NOT UNFAIRLY DENY HEALTH BENEFITS FOR ~~MEDICALLY--NECESSARY~~ HEALTH CARE SERVICES COVERED ~~EXPENSES~~.

~~(2)~~(3) [Sections 1 through ~~4~~ 6 7] do not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.

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.

~~(2)~~ THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT LEAST:

(A) A PROVISION THAT IF A COVERED PERSON RECEIVES EMERGENCY CARE FOR SERVICES SPECIFIED IN THE PREFERRED PROVIDER ~~ARRANGEMENT~~ AGREEMENT 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 DIFFERENCE IN BENEFIT LEVELS FOR HEALTH CARE SERVICES OF A PREFERRED PROVIDER AND BENEFIT LEVELS FOR THE SAME HEALTH CARE SERVICES OF A NONPREFERRED PROVIDER.

(2) A HEALTH CARE INSURER MAY NOT REQUIRE HOSPITAL

STAFF PRIVILEGES AS CRITERIA FOR DESIGNATION AS A PREFERRED PROVIDER IN A PREFERRED PROVIDER AGREEMENT.

SECTION 6. PERMISSIBLE PROVISIONS IN PROVIDER ~~ARRANGEMENTS~~ AGREEMENTS, INSURANCE POLICIES, AND SUBSCRIBER CONTRACTS. (1) A PROVIDER ~~ARRANGEMENT~~ AGREEMENT, INSURANCE POLICY, OR SUBSCRIBER CONTRACT ISSUED OR DELIVERED IN THIS STATE MAY CONTAIN CERTAIN OTHER COMPONENTS DESIGNED TO CONTROL THE COST AND IMPROVE THE QUALITY OF HEALTH CARE FOR ~~POLICYHOLDERS~~ INSUREDS AND SUBSCRIBERS, INCLUDING:

(A) 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,--AND--OTHER COST-SHARING---ARRANGEMENTS~~ PROVISION SETTING A PAYMENT DIFFERENCE FOR REIMBURSEMENT OF A NONPREFERRED PROVIDER AS COMPARED TO A PREFERRED PROVIDER. IF THE HEALTH BENEFIT PLAN CONTAINS A PAYMENT DIFFERENCE PROVISION, THE PAYMENT DIFFERENCE MAY NOT EXCEED 25% OF THE REIMBURSEMENT LEVEL AT WHICH A PREFERRED PROVIDER WOULD BE REIMBURSED. THE COMMISSIONER SHALL REVIEW DIFFERENCES BETWEEN COPAYMENTS, DEDUCTIBLES, AND OTHER COST-SHARING ARRANGEMENTS.

(B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS OF [SECTIONS 1 THROUGH 6], DESIGNED TO GIVE POLICYHOLDERS OR SUBSCRIBERS AN INCENTIVE TO CHOOSE A PARTICULAR PROVIDER.

(2) ALL TERMS OR CONDITIONS OF ~~A PROVIDER ARRANGEMENT~~, AN INSURANCE POLICY, OR SUBSCRIBER CONTRACT, EXCEPT THOSE ALREADY APPROVED BY THE COMMISSIONER, ARE SUBJECT TO THE PRIOR APPROVAL OF THE COMMISSIONER.

Section 7. Rules. The commissioner shall promulgate rules ~~prescribing reasonable standards relating to the accessibility and availability of health care services for persons insured under policies or contracts described in~~ NECESSARY TO IMPLEMENT THE PROVISIONS OF [~~section 3(1)(b)(ii)~~ SECTIONS 1 THROUGH 6 7].

Section 8. Codification instruction. Sections 1 through ~~4~~ 6 7 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through ~~4~~ 6 7.

SECTION 9. COORDINATION INSTRUCTION. IF SENATE BILL NO. 353, INCLUDING THE DEFINITION OF "HEALTH MAINTENANCE ORGANIZATION", IS NOT PASSED AND APPROVED, THE BRACKETED LANGUAGE IN SECTION 3(3)(C) OF THIS ACT IS VOID.

Section 10. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

SECTION 11. APPLICABILITY -- FILING WITH COMMISSIONER.

ON OR BEFORE JANUARY 1, 1988, A HEALTH CARE INSURER PERFORMING THE FUNCTIONS ENUMERATED IN THIS ACT SHALL NOTIFY THE COMMISSIONER OF ITS EXISTENCE AND CONTINUE TO OPERATE SUBJECT TO THE PROVISIONS OF THIS ACT.

Section 12. Effective date. ~~This act is~~ SECTION 6 7 AND THIS SECTION ARE effective on passage and approval.

-End-