



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.

1 Senate BILL NO. 371  
2 INTRODUCED BY [Signature]  
3

4 A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO  
5 ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO  
6 ISSUE POLICIES THAT INCLUDE INCENTIVES OR LIMIT  
7 REIMBURSEMENT FOR UTILIZING SERVICES RENDERED BY PROVIDERS  
8 WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN  
9 IMMEDIATE EFFECTIVE DATE."

10  
11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

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

14 Section 2. Definitions. As used in [sections 1 through  
15 4], the following definitions apply:

16 (1) "Health care services" means health care services  
17 or products rendered or sold by a provider within the scope  
18 of the provider's license or legal authorization, including  
19 but not limited to hospital, medical, surgical, dental,  
20 vision, and pharmaceutical services and products.

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

25 (3) "Insurer" means an insurance company or a health

1 service corporation authorized in this state to issue  
2 policies or subscriber contracts that reimburse an insured  
3 for expenses of health care services.

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

7 Section 3. Preferred provider agreements authorized.

8 (1) Notwithstanding any other provision of law to the  
9 contrary, an insurer may:

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

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

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

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

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



-2- INTRODUCED BILL  
SB - 371

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

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

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

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

-End-

APPROVED BY COMMITTEE  
ON PUBLIC HEALTH, WELFARE  
& SAFETY

1 STATEMENT OF INTENT

2 SENATE BILL 371

3 Senate Public Health, Welfare, and Safety Committee

4

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

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

14 (2) protect Montana health care insurance consumers.

15 The legislature further intends that the commissioner  
16 adopt rules to implement this act in accordance with  
17 33-1-313, which permits the commissioner:

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

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



SECOND READING  
SB 371

1 SENATE BILL NO. 371  
 2 INTRODUCED BY REGAN, HIMSL  
 3  
 4 A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO  
 5 ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO  
 6 ISSUE POLICIES THAT INCLUDE INCENTIVES ~~OR---LHMFF~~  
 7 REIMBURSEMENT FOR UTILIZING SERVICES RENDERED BY PROVIDERS  
 8 WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN  
 9 IMMEDIATE EFFECTIVE DATE."

10  
 11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:  
 12 Section 1. Short title. [Sections 1 through 4 6] may  
 13 be cited as the "Health Care Reimbursement Reform Act".

14 Section 2. Definitions. As used in [sections 1 through  
 15 4 6], the following definitions apply:

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

- 22 (A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;
- 23 (B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED;
- 24 OR
- 25 (C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

1 (2) "HEALTH BENEFIT PLAN" MEANS THE HEALTH INSURANCE  
 2 POLICY OR SUBSCRIBER ARRANGEMENT BETWEEN THE INSURED OR  
 3 SUBSCRIBER AND THE HEALTH CARE INSURER THAT DEFINES THE  
 4 COVERED SERVICES AND BENEFIT LEVELS AVAILABLE.

5 (3) "Health care services" means health care  
 6 services or products rendered or sold by a provider within  
 7 the scope of the provider's license or legal authorization,  
 8 including but not limited to hospital, medical, surgical,  
 9 dental, vision, and pharmaceutical services and products.

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

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

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

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

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



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

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

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

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

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

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

18 SECTION 4. INCENTIVES IN HEALTH BENEFIT PLANS. (1) A  
19 HEALTH CARE INSURER MAY ISSUE A POLICY OR A HEALTH BENEFIT  
20 PLAN THAT PROVIDES FOR INCENTIVES FOR COVERED PERSONS TO USE  
21 THE HEALTH CARE SERVICES OF PREFERRED PROVIDERS.

22 (2) THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT  
23 LEAST A PROVISION THAT IF A COVERED PERSON RECEIVES  
24 EMERGENCY CARE FOR SERVICES SPECIFIED IN THE PREFERRED  
25 PROVIDER ARRANGEMENT AND CANNOT REASONABLY REACH A PREFERRED

1 PROVIDER, THE CARE RENDERED DURING THE COURSE OF THE  
2 EMERGENCY WILL BE REIMBURSED AS THOUGH THE COVERED PERSON  
3 HAD BEEN TREATED BY A PREFERRED PROVIDER.

4 SECTION 5. PERMISSIBLE PROVISIONS IN PROVIDER  
5 ARRANGEMENTS, INSURANCE POLICIES, AND SUBSCRIBER CONTRACTS.

6 (1) A PROVIDER ARRANGEMENT, INSURANCE POLICY, OR SUBSCRIBER  
7 CONTRACT ISSUED OR DELIVERED IN THIS STATE MAY CONTAIN  
8 CERTAIN OTHER COMPONENTS DESIGNED TO CONTROL THE COST AND  
9 IMPROVE THE QUALITY OF HEALTH CARE FOR POLICYHOLDERS AND  
10 SUBSCRIBERS, INCLUDING:

11 (A) A PAYMENT DIFFERENTIAL OF NOT MORE THAN 25%  
12 BETWEEN USE OF PROVIDERS WITH ARRANGEMENTS WITH THE HEALTH  
13 CARE INSURER AND USE OF PROVIDERS WITHOUT SUCH ARRANGEMENTS.  
14 THE COMMISSIONER MAY BY RULE DETERMINE APPROPRIATE  
15 DIFFERENTIALS BETWEEN COPAYMENTS, DEDUCTIBLES, AND OTHER  
16 COST-SHARING ARRANGEMENTS.

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

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

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

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

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

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

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

-End-



1 STATEMENT OF INTENT

2 SENATE BILL 371

3 Senate Public Health, Welfare, and Safety Committee  
4

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

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

14 (2) protect Montana health care insurance consumers.

15 The legislature further intends that the commissioner  
16 adopt rules to implement this act in accordance with  
17 33-1-313, which permits the commissioner:

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

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

## 1 SENATE BILL NO. 371

2 INTRODUCED BY REGAN, HIMSL

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4 A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO  
5 ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO  
6 ISSUE POLICIES THAT INCLUDE INCENTIVES OR---~~REIMBURSEMENT~~  
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8 WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN  
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11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:12 Section 1. Short title. [Sections 1 through 4 6] may  
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3 SUBSCRIBER AND THE HEALTH CARE INSURER THAT DEFINES THE  
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17 for expenses of health care services.

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6 services of a provider that has entered into an agreement  
7 with the insurer pursuant to subsection (1)(a);-or\_

8 {ii}-provide-for-reimbursement-for-health-care-services  
9 only-if-the-services-are-rendered-by-a-provider--that--has  
10 entered--into--an--agreement--with--the--insurer-pursuant-to  
11 subsection-{i}{a}-

12 (2) A PREFERRED PROVIDER ARRANGEMENT ISSUED OR  
13 DELIVERED IN THIS STATE MAY NOT UNFAIRLY DENY HEALTH  
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12 BETWEEN USE OF PROVIDERS WITH ARRANGEMENTS WITH THE HEALTH  
13 CARE INSURER AND USE OF PROVIDERS WITHOUT SUCH ARRANGEMENTS.  
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17 (B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS  
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21 INSURANCE POLICY, OR SUBSCRIBER CONTRACT ARE SUBJECT TO THE  
22 PRIOR APPROVAL OF THE COMMISSIONER.

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

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

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

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

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

-End-

1 STATEMENT OF INTENT

2 SENATE BILL 371

3 Senate Public Health, Welfare, and Safety Committee

4

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

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

14 (2) protect Montana health care insurance consumers.

15 The legislature further intends that the commissioner  
16 adopt rules to implement this act in accordance with  
17 33-1-313, which permits the commissioner:

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

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



REFERENCE BILL  
SB-371

1                   SENATE BILL NO. 371  
2                   INTRODUCED BY REGAN, HIMSL  
3  
4   A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO  
5   ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO  
6   ISSUE POLICIES THAT INCLUDE INCENTIVES ~~OR~~ ~~---LIMIT~~  
7   REIMBURSEMENT FOR UTILIZING SERVICES RENDERED BY PROVIDERS  
8   WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN  
9   IMMEDIATE APPLICABILITY DATE AND AN EFFECTIVE DATE."  
10  
11   BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:  
12        Section 1. Short title. [Sections 1 through 4 6 7] may  
13   be cited as the "~~Health-Care-Reimbursement-Reform~~ PREFERRED  
14   PROVIDER AGREEMENTS Act".  
15        SECTION 2. PURPOSE. THE PURPOSE OF [SECTIONS 1 THROUGH  
16   7] IS TO ALLOW A HEALTH CARE INSURER PROVIDING DISABILITY  
17   INSURANCE BENEFITS TO NEGOTIATE AND CONTRACT WITH HEALTH  
18   CARE PROVIDERS TO:  
19        (1) PROVIDE HEALTH CARE SERVICES TO ITS INSURED OR  
20   SUBSCRIBERS AT A REDUCTION IN THE FEES CUSTOMARILY CHARGED  
21   BY THE PROVIDER; OR  
22        (2) ENTER INTO AGREEMENTS IN WHICH THE PARTICIPATING  
23   PROVIDERS ACCEPT NEGOTIATED FEES AS PAYMENT IN FULL FOR  
24   HEALTH CARE SERVICES THE HEALTH CARE INSURER IS OBLIGATED TO  
25   PROVIDE OR PAY FOR UNDER THE HEALTH BENEFIT PLAN.

1                   Section 3. Definitions. As used in [sections 1 through  
2   4 6 7], the following definitions apply:  
3                   (1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER  
4   SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF  
5   A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF  
6   SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT  
7   IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD  
8   REASONABLY EXPECT THAT:  
9                   (A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;  
10                   (B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED;  
11                   OR  
12                   (C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.  
13                   (2) "HEALTH BENEFIT PLAN" MEANS THE HEALTH INSURANCE  
14   POLICY OR SUBSCRIBER ARRANGEMENT BETWEEN THE INSURED OR  
15   SUBSCRIBER AND THE HEALTH CARE INSURER THAT DEFINES THE  
16   COVERED SERVICES AND BENEFIT LEVELS AVAILABLE.  
17                   (3) "HEALTH CARE INSURER" MEANS:  
18                   (A) AN INSURER THAT PROVIDES DISABILITY INSURANCE AS  
19   DEFINED IN 33-1-207;  
20                   (B) A HEALTH SERVICE CORPORATION AS DEFINED IN  
21   33-30-101;  
22                   (C) A HEALTH MAINTENANCE ORGANIZATION [AS DEFINED IN  
23   SECTION 2 OF SENATE BILL NO. 353];  
24                   (D) A FRATERNAL BENEFIT SOCIETY AS DEFINED IN  
25   33-7-102;

1 (E) AN ADMINISTRATOR AS DEFINED IN 33-17-601; OR  
 2 (F) ANY OTHER ENTITY REGULATED BY THE COMMISSIONER  
 3 THAT PROVIDES HEALTH COVERAGE.

4 ~~{1}{3}~~(4) "Health care services" means health care  
 5 services or products rendered or sold by a provider within  
 6 the scope of the provider's license or legal authorization  
 7 ~~including--but--not--limited-to-hospital, medical, surgical,~~  
 8 ~~dental, vision, and pharmaceutical services and products~~ OR  
 9 SERVICES PROVIDED UNDER TITLE 33, CHAPTER 22, PART 7.

10 ~~{2}{4}~~(5) "Insured" means an individual entitled to  
 11 reimbursement for expenses of health care services under a  
 12 policy or subscriber contract issued or administered by an  
 13 insurer.

14 ~~{3}{5}--"insurer"--means--an--insurance--company--or--a~~  
 15 ~~health-service-corporation-authorized-in-this-state-to-issue~~  
 16 ~~policies--or--subscriber-contracts-that-reimburse-an-insured~~  
 17 ~~for-expenses-of-health-care-services.~~

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

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

24 ~~{4}{6}~~(8) "Provider" means an individual or entity  
 25 licensed or legally authorized to provide health care

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

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

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

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

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

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

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

20 ~~{1}~~ include incentives for the insured to use the  
 21 services of a provider that has entered into an agreement  
 22 with the insurer pursuant to subsection (1)(a); ~~or,~~

23 ~~{2}~~ provide for reimbursement for health care services  
 24 only--if--the--services--are--rendered--by--a--provider--that--has  
 25 entered--into--an--agreement--with--the--insurer--pursuant--to

1 subsection-(1)(a)-

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

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

9 SECTION 5. INCENTIVES IN HEALTH BENEFIT PLANS. (1) A  
 10 HEALTH CARE INSURER MAY ISSUE A POLICY OR A HEALTH BENEFIT  
 11 PLAN THAT PROVIDES FOR INCENTIVES FOR COVERED PERSONS TO USE  
 12 THE HEALTH CARE SERVICES OF PREFERRED PROVIDERS.

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

15 (A) A PROVISION THAT IF A COVERED PERSON RECEIVES  
 16 EMERGENCY CARE FOR SERVICES SPECIFIED IN THE PREFERRED  
 17 PROVIDER ARRANGEMENT AGREEMENT AND CANNOT REASONABLY REACH A  
 18 PREFERRED PROVIDER, THE CARE RENDERED DURING THE COURSE OF  
 19 THE EMERGENCY WILL BE REIMBURSED AS THOUGH THE COVERED  
 20 PERSON HAD BEEN TREATED BY A PREFERRED PROVIDER; AND

21 (B) A PROVISION THAT CLEARLY IDENTIFIES THE DIFFERENCE  
 22 IN BENEFIT LEVELS FOR HEALTH CARE SERVICES OF A PREFERRED  
 23 PROVIDER AND BENEFIT LEVELS FOR THE SAME HEALTH CARE  
 24 SERVICES OF A NONPREFERRED PROVIDER.

25 (2) A HEALTH CARE INSURER MAY NOT REQUIRE HOSPITAL

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

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

10 (A) A PAYMENT--DIFFERENTIAL--OF--NOT--MORE--THAN--25%  
 11 BETWEEN--USE--OF--PROVIDERS--WITH--ARRANGEMENTS--WITH--THE--HEALTH  
 12 CARE--INSURER--AND--USE--OF--PROVIDERS--WITHOUT--SUCH--ARRANGEMENTS,  
 13 THE--COMMISSIONER--MAY--BY--RULE--DETERMINE--APPROPRIATE  
 14 DIFFERENTIALS--BETWEEN--COPAYMENTS,--DEDUCTIBLES,--AND--OTHER  
 15 COST--SHARING--ARRANGEMENTS PROVISION SETTING A PAYMENT  
 16 DIFFERENCE FOR REIMBURSEMENT OF A NONPREFERRED PROVIDER AS  
 17 COMPARED TO A PREFERRED PROVIDER. IF THE HEALTH BENEFIT PLAN  
 18 CONTAINS A PAYMENT DIFFERENCE PROVISION, THE PAYMENT  
 19 DIFFERENCE MAY NOT EXCEED 25% OF THE REIMBURSEMENT LEVEL AT  
 20 WHICH A PREFERRED PROVIDER WOULD BE REIMBURSED.

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

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



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

3 Section 7. Rules. The commissioner shall promulgate  
 4 rules prescribing--reasonable--standards--relating--to--the  
 5 accessibility--and--availability-of-health-care-services-for  
 6 persons-insured-under-policies--or--contracts--described--in  
 7 NECESSARY TO IMPLEMENT THE PROVISIONS OF [section  
 8 3(i)(b)(ii) SECTIONS 1 THROUGH 6 7].

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

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

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

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

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

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

-End-

# 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. "

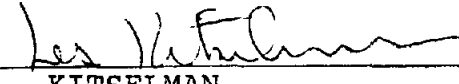
Insert: "The commissioner shall review differences between copayments, deductibles, and other cost-sharing arrangements."

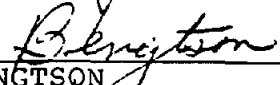
And that this Conference Committee report be adopted.

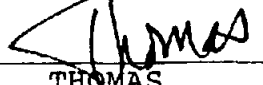
FOR THE SENATE

FOR THE HOUSE


  
\_\_\_\_\_  
REGAN, CHAIRPERSON

  
\_\_\_\_\_  
KITSELMAN

  
\_\_\_\_\_  
BENGTSON

  
\_\_\_\_\_  
THOMAS

  
\_\_\_\_\_  
HARDING

  
\_\_\_\_\_  
J. BROWN

ADOPT      REJECT

HOUSE

STANDING COMMITTEE REPORT

MARCH 26 19 87

SENATE BILL NO. 371  
MARCH 26 1987  
Page 2 of 5

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;

(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"

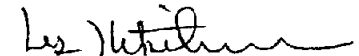
12) Page 2, line 25  
Strike: "the insurer's"

- 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"

*C SW*  


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"

*C SW*  


Chairman.

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

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

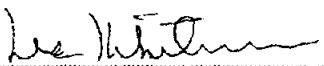
32) Page 5, line 6  
Strike: "6"  
Insert: "7"

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"

CSW

  
Chairman.

1 STATEMENT OF INTENT

2 SENATE BILL 371

3 Senate Public Health, Welfare, and Safety Committee

4  
5 A statement of intent is required for this bill because  
6 section 6 authorizes the commissioner of insurance to  
7 promulgate rules prescribing reasonable standards relating  
8 to the accessibility and availability of health care  
9 services for persons insured under policies or contracts  
10 described in section 3. The legislature intends that the  
11 rules adopted to implement this bill be designed to:

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

14 (2) protect Montana health care insurance consumers.

15 The legislature further intends that the commissioner  
16 adopt rules to implement this act in accordance with  
17 33-1-313, which permits the commissioner:

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

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

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~~ ~~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 INSURED 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;

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

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

4 ~~{1}{3}{4}~~ "Health care services" means health care  
5 services or products rendered or sold by a provider within  
6 the scope of the provider's license or legal authorization  
7 ~~including--but--not--limited--to--hospital,--medical,--surgical,~~  
8 ~~dental,--vision,--and--pharmaceutical--services--and--products~~ OR  
9 SERVICES PROVIDED UNDER TITLE 33, CHAPTER 22, PART 7.

10 ~~{2}{4}{5}~~ "Insured" means an individual entitled to  
11 reimbursement for expenses of health care services under a  
12 policy or subscriber contract issued or administered by an  
13 insurer.

14 ~~{3}{5}--"insurer"--means--an--insurance--company--or--a~~  
15 ~~health-service-corporation-authorized-in-this-state-to-issue~~  
16 ~~policies--or--subscriber-contracts-that-reimburse-an-insured~~  
17 ~~for-expenses-of-health-care-services.~~

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

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

24 ~~{4}{6}{8}~~ "Provider" means an individual or entity  
25 licensed or legally authorized to provide health care

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

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

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

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

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

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

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

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

23 ~~{ii}~~ ~~provide-for-reimbursement-for-health-care-services~~  
24 ~~only--if--the--services--are-rendered-by-a-provider-that-has~~  
25 ~~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.

(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 INSURED 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.

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

5 Section 7. Rules. The commissioner shall promulgate  
6 rules ~~prescribing--reasonable--standards--relating--to--the~~  
7 ~~accessibility--and--availability-of-health-care-services-for~~  
8 ~~persons--insured--under--policies--or--contracts--described--in~~  
9 NECESSARY TO IMPLEMENT THE PROVISIONS OF [section  
10 3(1)(b)(ii) SECTIONS 1 THROUGH 6 7].

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

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

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

25 SECTION 11. APPLICABILITY -- FILING WITH COMMISSIONER.

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

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

-End-