HOUSE BILL 75

Introduced by T. Nelson

12/29	Introduced
12/30	Referred to Human Services & Aging
1/04	First Reading
1/08	Hearing
1/29	Tabled in Committee
2/16	Committee Report--Bill Passed as Amended
2/20	2nd Reading Passed as Amended
2/20	Taken from Engrossing and Rereferred to Appropriations
3/17	Tabled in Committee

HOUSE BILL NO. 75

INTRODUCED BY T. NELSON

BY REQUEST OF THE JOINT INTERIM SUBCOMMITTEE

ON MANDATED HEALTH INSURANCE BENEFITS

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING A COMMISSION TO REVIEW MANDATED BENEFITS; APPROPRIATING MONEY FOR THE COMMISSION; ESTABLISHING CRITERIA AND PROCEDURES FOR REVIEWING PROPOSALS TO REQUIRE A NEW MANDATED HEALTH INSURANCE BENEFIT OR TO AMEND OR REPEAL AN EXISTING MANDATED BENEFIT; ESTABLISHING REQUIRED CONTENTS FOR PROPOSALS; AMENDING SECTION 5-11-210, MCA; AND PROVIDING AN EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section 2] grants rulemaking authority to the commission to review mandated benefits. The rules should address, at a minimum, the following areas:

(1) the style and format required for proposals;

(2) guidelines for use in reviewing the completeness and validity of each proposal;

(3) the types of evidence or documentation required by the commission to determine the value of the proposed or existing mandated benefit; and

(4) the procedure for reviewing the proposal, including provisions for public comment.

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

NEW SECTION. **Section 1.** **Definitions.** As used in [sections 1 through 5], the following definitions apply:

(1) "Commission" means the commission to review mandated benefits provided for in [section 2].

(2) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or the practice of a profession.

(3) "Mandated benefit" means state legislation that prescribes the content of disability insurance purchased from commercial insurers. The term includes extended coverages for certain categories of individuals; covered benefits, including mandated options and benefits limited to certain types of policies; and coverages for freedom of choice of practitioners.

NEW SECTION. **Section 2.** **Commission to review mandated benefits -- composition -- allocation -- rulemaking authority.**

(1) There is a commission to review mandated benefits. The commission consists of nine members. The commissioner of insurance or a designee and the director of the department

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of health and environmental sciences or a designee shall serve as nonvoting members. The remaining seven members are voting members. The seven members must be appointed by the governor as follows:

(a) one representative of the general public who is not employed in the insurance industry or in the provision of health care and who is not an officer or employee of a labor organization;

(b) one administrator of a health care facility, as defined in 50-5-101;

(c) one health care provider who is not actively employed in the mental health, mental illness, or addictive disease treatment field;

(d) one licensed or certified mental health, mental illness, or addictive disease care provider;

(e) one employer who is not active in the health care or insurance field;

(f) one representative of a collective bargaining labor organization; and

(g) one representative or licensed insurance producer of a company or organization licensed to provide disability insurance in Montana.

(2) Each commission member appointed by the governor shall serve a 4-year term, except that the governor shall designate four of the initial members to serve 4-year terms

and three to serve 2-year terms. A member appointed to fill a vacancy shall serve until the end of that term.

(3) The commission shall elect one of its members as presiding officer and one as vice presiding officer.

(4) The commission is allocated to the commissioner of insurance for administrative purposes only as prescribed in 2-15-121.

(5) The commission shall adopt rules in accordance with the Montana Administrative Procedure Act to implement [sections 1 through 5].

NEW SECTION. **Section 3.** Commission review and report. (1) The commission shall review and assess the merits of each proposal to:

(a) require a new mandated benefit; or

(b) amend or repeal an existing mandated benefit.

(2) A proposal subject to review under subsection (1) must be submitted to the commission at least 6 months before the first day of the next regular legislative session.

(3) After the commission has initiated its review, it may request additional information that it considers necessary to complete its assessment of the proposal.

(4) The commission shall hold at least one public hearing during which the applicant and members of the public have an opportunity to testify. The commission may consider more than one proposal at a public hearing.

(5) The commission shall prepare and, as provided in 5-11-210, submit a report to the legislature for its next regular session. The report must include but is not limited to the commission's recommendation as to whether the proposal merits consideration by the legislature. If the commission declines to recommend a proposal, the commission shall state in its report the reasons for its action. The report to the legislature may include more than one proposal review.

(6) The legislature may not consider a proposal to mandate a new health insurance benefit or to repeal or amend an existing mandated benefit unless the commission certifies no later than December 31 preceding the beginning of a regular session that the proposal has been reviewed.

NEW SECTION. **Section 4. Meetings -- compensation -- staff assistance.** (1) The commission shall meet when sufficient requests for reviews of proposals have been received or not later than the first day of August of the year preceding a regular session of the legislature, unless no requests have been received.

(2) Members of the commission are entitled to expenses as provided in 2-18-501 through 2-18-503.

(3) The commissioner of insurance and the department of health and environmental sciences shall provide staff assistance to the commission.

NEW SECTION. **Section 5. Contents of proposal.** The proposal submitted by the applicant must include but is not limited to the following information, to the extent that it is available:

(1) the social impact of mandating the benefit, including:

(a) the extent to which the treatment or service is used by a significant portion of the population;

(b) the extent to which the treatment or service is available to the population;

(c) the extent to which insurance coverage for this treatment or service is already available;

(d) if coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(e) if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(f) the level of public demand and the level of demand from health care providers for the treatment or service;

(g) the level of public demand and the level of demand from health care providers for individual or group insurance coverage of the treatment or service;

(h) the level of interest of collective bargaining organizations in negotiating privately for inclusion of this

coverage in group contracts;

(i) the likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(j) the relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(k) the alternatives to meeting the identified need;

(l) whether the benefit is a medical need or a broader social need and whether it is consistent with the role of health insurance;

(m) the impact on the market of any social stigma attached to the benefit;

(n) the impact of this benefit on the availability of other benefits currently being offered; and

(o) the impact of the benefit as it relates to employers shifting to self-insured plans;

(2) the financial impact of mandating the benefit, including:

(a) the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(b) the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

(c) the extent to which the mandated benefit might serve as an alternative for more expensive or less expensive treatment or service;

(d) the methods that will be instituted to manage the use and costs of the proposed mandated benefit;

(e) the extent to which the insurance coverage may affect the number and types of providers of the mandated benefit over the next 5 years;

(f) the extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(g) the impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(h) the impact of this coverage on the total cost of health care; and

(i) the effects on the cost of health care to employers and employees, including the financial impact on small businesses, medium-sized businesses, and large businesses;

(3) the medical efficacy of mandating the benefit, including:

(a) the contribution of the benefit to the quality of patient care and the health status of the population, such as the results of any research demonstrating the medical

efficacy of the treatment or service compared to alternatives or to not providing the treatment or service; and

(b) if the legislation seeks to mandate coverage of an additional class of practitioners:

(i) the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

(ii) the methods used by the appropriate professional organization to ensure clinical proficiency;

(4) the effects of balancing the social, economic, and medical efficacy considerations, including:

(a) the extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders; and

(b) the extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders.

Section 6. Section 5-11-210, MCA, is amended to read:

"**5-11-210. Clearinghouse for reports to legislature.** (1) For the purposes of this section, "report" means:

(a) a document required to be prepared for the legislature as required in any of the sections listed in subsection (10); and

(b) unless otherwise provided by law, any other report required by law to be given to or filed with the legislature.

(2) On or before September 1 of each year preceding the convening of a regular session of the legislature, an entity required to report to the legislature shall provide, in writing, to the executive director of the legislative council:

(a) the final title of the report;

(b) an abstract or description of the contents of the report, not to exceed one page;

(c) a recommendation on how many copies of the report should be provided to the legislature;

(d) the reasons why the number of copies recommended is, in the opinion of the reporting entity, the appropriate number of copies;

(e) an estimated cost for each copy of the report; and

(f) the date on which the entity will deliver the final, published copies of the report to the legislature.

(3) After considering all of the information available about the report, including the number of legislators requesting copies of the report pursuant to subsection (7), the legislative council or the executive director shall, in writing, direct the reporting entity to provide a specific number of copies. The number of copies required is at the

sole discretion of the legislative council. The legislative council or the executive director may require the reporting entity to mail the copies of the report.

(4) The legislative council may require that the report be submitted in an electronic format useable on the legislature's current computer hardware, in a microform, such as microfilm or microfiche, or in a CD-ROM format, meaning compact disc read-only memory.

(5) Costs of preparing and distributing a report to the legislature, including writing, printing, postage, distribution, and all other costs, accrue to the reporting agency. Costs incurred in meeting the requirements of this section may not accrue to the legislative council.

(6) The executive director of the legislative council shall cause to be prepared a list of all reports required to be presented to the legislature from the list of titles received under subsection (2).

(7) The executive director shall, as soon as possible following a general election, mail to each holdover senator, senator-elect, and representative-elect a list of the titles of the reports, along with the abstracts prepared pursuant to subsection (2)(b), available from the legislative council. The list must include a form on which each member or member-elect receiving the list may indicate the report or reports that the member or member-elect would like to

receive.

(8) The executive director or the legislative council shall make copies of reports requested pursuant to subsection (7) available to those members or members-elect by either requiring that copies be mailed pursuant to subsection (3) or by delivering copies of the reports during the first week of the legislative session.

(9) The executive director of the legislative council may keep as many copies of a report as he considers necessary, and copies of the report may be discarded at his discretion.

(10) (a) A report to the legislature includes a report required to be made by a board, bureau, commission, committee, council, department, division, fund, authority, or officer of the state or a local government in 1-11-204, 2-4-411, 2-7-104, 2-8-112, 2-8-203, 2-8-207, 2-8-208, 2-15-2021, 2-18-209, 2-18-811, 2-18-1103, 3-1-702, 3-1-1126, 5-5-216, 5-13-304, 5-17-103, 5-18-203, 5-19-108, 10-4-102, 15-1-205, 17-4-107, 17-5-1650, 18-7-303, 19-4-201, 20-9-346, 20-25-236, 20-25-301, 22-3-107, 23-7-203, [section 3], 33-22-1513, 37-1-106, 39-6-101, 39-51-407, 44-2-304, 44-13-103, 46-23-316, 53-2-1107, 53-6-110, 53-20-104, 53-21-104, 53-24-204, 53-24-210, 53-30-133, 69-1-404, 72-16-202, 75-1-203, 75-1-1101, 75-7-304, 75-10-533, 75-10-704, 76-11-203, 76-12-109, 80-7-713, 80-12-402,

82-11-161, 85-1-621, 85-2-105, 87-2-724, 87-5-123, 90-3-203, or 90-4-111.

(b) The procedure outlined in this section may also be used for a report required to be made to the legislature under the Multistate Tax Compact contained in 15-1-601, the Vehicle Equipment Safety Compact contained in 61-2-201, the Multistate Highway Transportation Agreement contained in 61-10-1101, or the Western Interstate Nuclear Compact contained in 90-5-201."

NEW SECTION. **Section 7.** Appropriation. There is appropriated for the biennium ending June 30, 1995, $11,000 from the general fund to the commissioner of insurance for use by the commission to review mandated benefits established in [section 2].

NEW SECTION. **Section 8.** Effective date. [This act] is effective July 1, 1993.

-End-

APPROVED BY COMM. ON
HUMAN SERVICES AND AGING

HOUSE BILL NO. 75

INTRODUCED BY T. NELSON

BY REQUEST OF THE JOINT INTERIM SUBCOMMITTEE

ON MANDATED HEALTH INSURANCE BENEFITS

A BILL FOR AN ACT ENTITLED: "AN ACT ~~CREATING--A--COMMISSION TO~~ PROVIDING FOR REVIEW OF MANDATED BENEFITS BY THE INSURANCE COMMISSIONER; ~~APPROPRIATING---MONEY---FOR---THE COMMISSION;~~ ESTABLISHING CRITERIA AND PROCEDURES FOR REVIEWING PROPOSALS TO REQUIRE A NEW MANDATED HEALTH INSURANCE BENEFIT OR TO AMEND OR REPEAL AN EXISTING MANDATED BENEFIT; ESTABLISHING REQUIRED CONTENTS FOR PROPOSALS; APPROPRIATING MONEY; AMENDING SECTION 5-11-210, MCA; AND PROVIDING AN EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section 2] grants rulemaking authority to the ~~commission~~ INSURANCE COMMISSIONER to review mandated benefits. The rules should address, at a minimum, the following areas:

(1) the style and format required for proposals;

(2) guidelines for use in reviewing the completeness and validity of each proposal;

(3) the types of evidence or documentation required by the ~~commission~~ COMMISSIONER to determine the value of the proposed or existing mandated benefit; and

(4) the procedure for reviewing the proposal, including provisions for public comment.

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

NEW SECTION. **Section 1.** **Definitions.** As used in [sections 1 through 5], the following definitions apply:

(1) "ADVISORY COUNCIL" MEANS THE ADVISORY COUNCIL REQUIRED BY [SECTION 4].

~~(1)~~(2) "~~Commission~~ COMMISSIONER" means the ~~commission to review mandated benefits provided for in section 2~~ COMMISSIONER OF INSURANCE PROVIDED FOR IN 2-15-1903.

~~(2)~~(3) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or the practice of a profession.

~~(3)~~(4) "Mandated benefit" means state legislation that prescribes the content of POLICIES OF disability insurance ~~purchased from commercial insurers~~ OR CERTIFICATES ISSUED PURSUANT TO THOSE POLICIES BY INSURERS OR HEALTH SERVICE CORPORATIONS. The term includes extended coverages for certain categories of individuals; covered benefits, including mandated options and benefits limited to certain types of policies; and coverages for freedom of choice of practitioners.

NEW SECTION. **Section 2.** ~~Commission to review mandated benefits------composition-------allocation--------rulemaking authority.~~

~~(1)--There--is-a-commission-to-review-mandated-benefits. The-commission-consists-of-nine-members.-The-commissioner-of insurance-or-a-designee-and-the-director-of--the--department of--health--and--environmental--sciences-or-a-designee-shall serve-as-nonvoting-members.-The-remaining-seven-members--are voting--members.--The-seven-members-must-be-appointed-by-the governor-as-follows:~~

~~(a)--one-representative-of-the-general-public-who-is-not employed-in-the-insurance-industry-or-in--the--provision--of health-care-and-who-is-not-an-officer-or-employee-of-a-labor organization;~~

~~(b)--one--administrator--of--a--health-care-facility,-as defined-in-50-5-101;~~

~~(c)--one--health--care--provider--who--is--not--actively employed-in-the-mental-health,-mental-illness,-or--addictive disease-treatment-field;~~

~~(d)--one--licensed--or--certified--mental-health,-mental illness,-or-addictive-disease-care-provider;~~

~~(e)--one-employer-who-is-not-active-in-the--health--care or-insurance-field;~~

~~(f)--one-representative-of-a-collective-bargaining-labor organization;-and~~

~~(g)--one--representative--or-licensed-insurance-producer of-a-company-or-organization-licensed-to-provide--disability insurance-in-Montana.~~

~~(2)--Each--commission--member--appointed-by-the-governor shall-serve-a-4-year-term,-except-that--the--governor--shall designate--four-of-the-initial-members-to-serve-4-year-terms and-three-to-serve-2-year-terms.-A-member-appointed-to--fill a-vacancy-shall-serve-until-the-end-of-that-term.~~

~~(3)--The--commission--shall--elect-one-of-its-members-as presiding-officer-and-one-as-vice-presiding-officer.~~

~~(4)--The-commission-is-allocated-to-the-commissioner--of insurance--for-administrative-purposes-only-as-prescribed-in 2-15-121.~~ COMMISSIONER REVIEW OF PROPOSAL FOR MANDATED BENEFITS. (1) AN INDIVIDUAL, PERSON, GROUP, OR ASSOCIATION INTENDING TO PRESENT A PROPOSAL FOR A MANDATED BENEFIT TO THE LEGISLATURE MAY PRESENT THE PROPOSAL TO THE COMMISSIONER AT LEAST 6 MONTHS BEFORE THE CONVENING OF A REGULAR SESSION OF THE LEGISLATURE. A PROPOSAL SUBMITTED TO THE COMMISSIONER MUST CONTAIN THOSE MATTERS REQUIRED BY [SECTION 5] AND MUST CONFORM TO THE RULES ADOPTED BY THE COMMISSIONER.

~~(5)~~(2) The commission COMMISSIONER shall adopt rules in accordance with the Montana Administrative Procedure Act to implement [sections 1 through 5].

NEW SECTION. **Section 3.** ~~Commission~~ COMMISSIONER review and report. (1) The commission COMMISSIONER shall review and

assess the merits of each proposal to:

(a) require a new mandated benefit; or

(b) amend or repeal an existing mandated benefit.

(2) A proposal subject to review under subsection (1) must be submitted to the ~~commission~~ COMMISSIONER at least 6 months before the first day of the next regular legislative session.

(3) After the ~~commission~~ COMMISSIONER has initiated ~~its~~ A review, ~~it~~ THE COMMISSIONER may request FROM THE ENTITY PRESENTING THE PROPOSAL FOR A MANDATED BENEFIT OR FROM ANY STATE AGENCY additional information that ~~it~~ THE COMMISSIONER considers necessary to complete ~~its~~ THE assessment of the proposal.

(4) The ~~commission~~ COMMISSIONER shall hold at least one public hearing during which the ~~applicant~~ ENTITY PRESENTING THE PROPOSAL FOR A MANDATED BENEFIT and members of the public have an opportunity to testify. The ~~commission~~ COMMISSIONER may consider more than one proposal at a public hearing. THE ADVISORY COUNCIL REQUIRED BY [SECTION 4] SHALL ATTEND THE HEARING AND ADVISE THE COMMISSIONER CONCERNING THE MATTERS CONTAINED IN THE PROPOSAL SUBMITTED TO THE COMMISSIONER.

(5) The ~~commission~~ COMMISSIONER shall prepare and, as provided in 5-11-210, submit a report to the legislature for its next regular session. The report must include but is not

limited to the ~~commission's~~ COMMISSIONER'S recommendation as to whether the proposal merits consideration by the legislature. If the ~~commission~~ COMMISSIONER declines to recommend a proposal, the ~~commission~~ COMMISSIONER shall state in ~~its~~ THE report the reasons for ~~its~~ THE action. The report to the legislature may include more than one proposal review.

~~(6) The legislature may not consider a proposal to mandate a new health insurance benefit or to repeal or amend an existing mandated benefit unless the commission certifies no later than December 31 preceding the beginning of a regular session that the proposal has been reviewed.~~

NEW SECTION. **Section 4.** ~~Meetings -- compensation -- staff assistance. (1) The commission shall meet when sufficient requests for reviews of proposals have been received or not later than the first day of August of the year preceding a regular session of the legislature, unless no requests have been received.~~

~~(2) Members of the commission are entitled to expenses as provided in 2-18-501 through 2-18-503.~~

~~(3) The commissioner of insurance and the department of health and environmental sciences shall provide staff assistance to the commission.~~ ADVISORY COUNCIL -- MEMBERSHIP -- COMPENSATION -- MEETINGS. (1) THE COMMISSIONER SHALL APPOINT AN ADVISORY COUNCIL TO ADVISE THE COMMISSIONER

CONCERNING THE DUTIES OF THE COMMISSIONER UNDER [SECTION 3]. THE COUNCIL CONSISTS OF EIGHT MEMBERS. THE DIRECTOR OF HEALTH AND ENVIRONMENTAL SCIENCES OR THE DIRECTOR'S DESIGNEE IS AN EX OFFICIO MEMBER. THE OTHER SEVEN MEMBERS MUST BE APPOINTED BY THE COMMISSIONER AS FOLLOWS:

(A) ONE REPRESENTATIVE OF THE GENERAL PUBLIC WHO IS NOT EMPLOYED IN THE INSURANCE INDUSTRY OR IN THE PROVISION OF HEALTH CARE AND WHO IS NOT AN OFFICER OR EMPLOYEE OF A LABOR ORGANIZATION;

(B) ONE ADMINISTRATOR OF A HEALTH CARE FACILITY, AS DEFINED IN 50-5-101;

(C) ONE HEALTH CARE PROVIDER WHO IS NOT ACTIVELY EMPLOYED IN THE MENTAL HEALTH, MENTAL ILLNESS, OR ADDICTIVE DISEASE TREATMENT FIELD;

(D) ONE LICENSED OR CERTIFIED MENTAL HEALTH, MENTAL ILLNESS, OR ADDICTIVE DISEASE CARE PROVIDER;

(E) ONE EMPLOYER WHO IS NOT ACTIVE IN THE HEALTH CARE OR INSURANCE FIELD;

(F) ONE REPRESENTATIVE OF A COLLECTIVE BARGAINING LABOR ORGANIZATION; AND

(G) ONE REPRESENTATIVE OR LICENSED INSURANCE PRODUCER OF A COMPANY OR ORGANIZATION LICENSED TO PROVIDE DISABILITY INSURANCE IN MONTANA.

(2) EACH COUNCIL MEMBER APPOINTED BY THE COMMISSIONER SHALL SERVE A 4-YEAR TERM, EXCEPT THAT THE COMMISSIONER

SHALL DESIGNATE FOUR OF THE INITIAL MEMBERS TO SERVE 4-YEAR TERMS AND THREE TO SERVE 2-YEAR TERMS. A MEMBER APPOINTED TO FILL A VACANCY SHALL SERVE UNTIL THE END OF THAT TERM.

(3) THE COUNCIL SHALL ELECT ONE OF ITS MEMBERS AS PRESIDING OFFICER AND ONE AS VICE PRESIDING OFFICER.

(4) EXCEPT AS PROVIDED IN THIS SECTION, THE COUNCIL MUST BE APPOINTED, COMPENSATED, REIMBURSED, AND ADMINISTERED AS PROVIDED IN 2-15-122.

(5) THE COUNCIL SHALL MEET AT THE TIME REQUIRED BY [SECTION 3(4)] AND AT OTHER TIMES AS REQUESTED BY THE COMMISSIONER.

NEW SECTION. **Section 5.** Contents of proposal. The proposal ~~submitted by the applicant~~ FOR THE MANDATED BENEFIT must include but is not limited to the following information, to the extent that it is available:

(1) the social impact of mandating the benefit, including:

(a) the extent to which the treatment or service is used by a significant portion of the population;

(b) the extent to which the treatment or service is available to the population;

(c) the extent to which insurance coverage for this treatment or service is already available;

(d) if coverage is not generally available, the extent to which the lack of coverage results in persons being

unable to obtain necessary health care treatment;

(e) if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(f) the level of public demand and the level of demand from health care providers for the treatment or service;

(g) the level of public demand and the level of demand from health care providers for individual or group insurance coverage of the treatment or service;

(h) the level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;

(i) the likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(j) the relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(k) the alternatives to meeting the identified need;

(l) whether the benefit is a medical need or a broader social need and whether it is consistent with the role of health insurance;

(m) the impact on the market of any social stigma attached to the benefit;

(n) the impact of this benefit on the availability of

other benefits currently being offered; and

(o) the impact of the benefit as it relates to employers shifting to self-insured plans;

(2) the financial impact of mandating the benefit, including:

(a) the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(b) the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

(c) the extent to which the mandated benefit might serve as an alternative for more expensive or less expensive treatment or service;

(d) the methods that will be instituted to manage the use and costs of the proposed mandated benefit;

(e) the extent to which the insurance coverage may affect the number and types of providers of the mandated benefit over the next 5 years;

(f) the extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(g) the impact of indirect costs, which are costs other than premiums and administrative costs, on the question of

the costs and benefits of coverage;

(h) the impact of this coverage on the total cost of health care; and

(i) the effects on the cost of health care to employers and employees, including the financial impact on small businesses, medium-sized businesses, and large businesses;

(3) the medical efficacy of mandating the benefit, including:

(a) the contribution of the benefit to the quality of patient care and the health status of the population, such as the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or to not providing the treatment or service; and

(b) if the legislation seeks to mandate coverage of an additional class of practitioners:

(i) the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

(ii) the methods used by the appropriate professional organization to ensure clinical proficiency;

(4) the effects of balancing the social, economic, and medical efficacy considerations, including:

(a) the extent to which the need for coverage outweighs

the costs of mandating the benefit for all policyholders; and

(b) the extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders.

Section 6. Section 5-11-210, MCA, is amended to read:

"**5-11-210. Clearinghouse for reports to legislature.** (1) For the purposes of this section, "report" means:

(a) a document required to be prepared for the legislature as required in any of the sections listed in subsection (10); and

(b) unless otherwise provided by law, any other report required by law to be given to or filed with the legislature.

(2) On or before September 1 of each year preceding the convening of a regular session of the legislature, an entity required to report to the legislature shall provide, in writing, to the executive director of the legislative council:

(a) the final title of the report;

(b) an abstract or description of the contents of the report, not to exceed one page;

(c) a recommendation on how many copies of the report should be provided to the legislature;

(d) the reasons why the number of copies recommended

is, in the opinion of the reporting entity, the appropriate number of copies;

(e) an estimated cost for each copy of the report; and

(f) the date on which the entity will deliver the final, published copies of the report to the legislature.

(3) After considering all of the information available about the report, including the number of legislators requesting copies of the report pursuant to subsection (7), the legislative council or the executive director shall, in writing, direct the reporting entity to provide a specific number of copies. The number of copies required is at the sole discretion of the legislative council. The legislative council or the executive director may require the reporting entity to mail the copies of the report.

(4) The legislative council may require that the report be submitted in an electronic format useable on the legislature's current computer hardware, in a microform, such as microfilm or microfiche, or in a CD-ROM format, meaning compact disc read-only memory.

(5) Costs of preparing and distributing a report to the legislature, including writing, printing, postage, distribution, and all other costs, accrue to the reporting agency. Costs incurred in meeting the requirements of this section may not accrue to the legislative council.

(6) The executive director of the legislative council

shall cause to be prepared a list of all reports required to be presented to the legislature from the list of titles received under subsection (2).

(7) The executive director shall, as soon as possible following a general election, mail to each holdover senator, senator-elect, and representative-elect a list of the titles of the reports, along with the abstracts prepared pursuant to subsection (2)(b), available from the legislative council. The list must include a form on which each member or member-elect receiving the list may indicate the report or reports that the member or member-elect would like to receive.

(8) The executive director or the legislative council shall make copies of reports requested pursuant to subsection (7) available to those members or members-elect by either requiring that copies be mailed pursuant to subsection (3) or by delivering copies of the reports during the first week of the legislative session.

(9) The executive director of the legislative council may keep as many copies of a report as he considers necessary, and copies of the report may be discarded at his discretion.

(10) (a) A report to the legislature includes a report required to be made by a board, bureau, commission, committee, council, department, division, fund, authority,

or officer of the state or a local government in 1-11-204, 2-4-411, 2-7-104, 2-8-112, 2-8-203, 2-8-207, 2-8-208, 2-15-2021, 2-18-209, 2-18-811, 2-18-1103, 3-1-702, 3-1-1126, 5-5-216, 5-13-304, 5-17-103, 5-18-203, 5-19-108, 10-4-102, 15-1-205, 17-4-107, 17-5-1650, 18-7-303, 19-4-201, 20-9-346, 20-25-236, 20-25-301, 22-3-107, 23-7-203, [section 3], 33-22-1513, 37-1-106, 39-6-101, 39-51-407, 44-2-304, 44-13-103, 46-23-316, 53-2-1107, 53-6-110, 53-20-104, 53-21-104, 53-24-204, 53-24-210, 53-30-133, 69-1-404, 72-16-202, 75-1-203, 75-1-1101, 75-7-304, 75-10-533, 75-10-704, 76-11-203, 76-12-109, 80-7-713, 80-12-402, 82-11-161, 85-1-621, 85-2-105, 87-2-724, 87-5-123, 90-3-203, or 90-4-111.

(b) The procedure outlined in this section may also be used for a report required to be made to the legislature under the Multistate Tax Compact contained in 15-1-601, the Vehicle Equipment Safety Compact contained in 61-2-201, the Multistate Highway Transportation Agreement contained in 61-10-1101, or the Western Interstate Nuclear Compact contained in 90-5-201."

NEW SECTION. **Section 7.** Appropriation. There is appropriated for the biennium ending June 30, 1995, $11,000 from the general fund to the commissioner of insurance for use by the ~~commission~~ COMMISSIONER to review mandated benefits ~~established in [section 2]~~.

NEW SECTION. **Section 8.** Effective date. [This act] is effective July 1, 1993.

-End-

HOUSE BILL NO. 75

INTRODUCED BY T. NELSON

BY REQUEST OF THE JOINT INTERIM SUBCOMMITTEE

ON MANDATED HEALTH INSURANCE BENEFITS

A BILL FOR AN ACT ENTITLED: "AN ACT ~~CREATING--A--COMMISSION TO~~ PROVIDING FOR REVIEW OF MANDATED BENEFITS BY THE INSURANCE COMMISSIONER; ~~APPROPRIATING---MONEY---FOR---THE COMMISSION;~~ ESTABLISHING CRITERIA AND PROCEDURES FOR REVIEWING PROPOSALS TO REQUIRE A NEW MANDATED HEALTH INSURANCE BENEFIT OR TO AMEND OR REPEAL AN EXISTING MANDATED BENEFIT; ESTABLISHING REQUIRED CONTENTS FOR PROPOSALS; APPROPRIATING MONEY; AMENDING SECTION 5-11-210, MCA; AND PROVIDING AN EFFECTIVE DATE AND A TERMINATION DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section 2] grants rulemaking authority to the ~~commission~~ INSURANCE COMMISSIONER to review mandated benefits. The rules should address, at a minimum, the following areas:

(1) the style and format required for proposals;

(2) guidelines for use in reviewing the completeness and validity of each proposal;

(3) the types of evidence or documentation required by the ~~commission~~ COMMISSIONER to determine the value of the proposed or existing mandated benefit; and

(4) the procedure for reviewing the proposal, including provisions for public comment.

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

NEW SECTION. **Section 1.** **Definitions.** As used in [sections 1 through 5], the following definitions apply:

(1) "ADVISORY COUNCIL" MEANS THE ADVISORY COUNCIL REQUIRED BY [SECTION 4].

~~(1)~~(2) "~~Commission~~ COMMISSIONER" means the ~~commission to review mandated benefits provided for in [section 2]~~ COMMISSIONER OF INSURANCE PROVIDED FOR IN 2-15-1903.

~~(2)~~(3) "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or the practice of a profession.

~~(3)~~(4) "Mandated benefit" means state legislation that prescribes the content of POLICIES OF disability insurance ~~purchased from commercial insurers~~ OR CERTIFICATES ISSUED PURSUANT TO THOSE POLICIES BY INSURERS OR HEALTH SERVICE CORPORATIONS. The term includes extended coverages for certain categories of individuals; covered benefits, including mandated options and benefits limited to certain types of policies; and coverages for freedom of choice of practitioners.

NEW SECTION. **Section 2.** ~~Commission to review mandated benefits composition allocation rulemaking authority.~~

~~(1) There is a commission to review mandated benefits. The commission consists of nine members. The commissioner of insurance or a designee and the director of the department of health and environmental sciences or a designee shall serve as nonvoting members. The remaining seven members are voting members. The seven members must be appointed by the governor as follows:~~

~~(a) one representative of the general public who is not employed in the insurance industry or in the provision of health care and who is not an officer or employee of a labor organization;~~

~~(b) one administrator of a health care facility, as defined in 50-5-101;~~

~~(c) one health care provider who is not actively employed in the mental health, mental illness, or addictive disease treatment field;~~

~~(d) one licensed or certified mental health, mental illness, or addictive disease care provider;~~

~~(e) one employer who is not active in the health care or insurance field;~~

~~(f) one representative of a collective bargaining labor organization; and~~

~~(g) one representative or licensed insurance producer of a company or organization licensed to provide disability insurance in Montana.~~

~~(2) Each commission member appointed by the governor shall serve a 4-year term, except that the governor shall designate four of the initial members to serve 4-year terms and three to serve 2-year terms. A member appointed to fill a vacancy shall serve until the end of that term.~~

~~(3) The commission shall elect one of its members as presiding officer and one as vice presiding officer.~~

~~(4) The commission is allocated to the commissioner of insurance for administrative purposes only as prescribed in 2-15-121.~~ COMMISSIONER REVIEW OF PROPOSAL FOR MANDATED BENEFITS. (1) AN INDIVIDUAL, PERSON, GROUP, OR ASSOCIATION INTENDING TO PRESENT A PROPOSAL FOR A MANDATED BENEFIT TO THE LEGISLATURE MAY PRESENT THE PROPOSAL TO THE COMMISSIONER AT LEAST 6 MONTHS BEFORE THE CONVENING OF A REGULAR SESSION OF THE LEGISLATURE. A PROPOSAL SUBMITTED TO THE COMMISSIONER MUST CONTAIN THOSE MATTERS REQUIRED BY [SECTION 5] AND MUST CONFORM TO THE RULES ADOPTED BY THE COMMISSIONER.

~~(5)~~(2) The ~~commission~~ COMMISSIONER shall adopt rules in accordance with the Montana Administrative Procedure Act to implement [sections 1 through 5].

NEW SECTION. **Section 3.** ~~Commission~~ COMMISSIONER review and report. (1) The ~~commission~~ COMMISSIONER shall review and

assess the merits of each proposal to:

(a) require a new mandated benefit; or

(b) amend or repeal an existing mandated benefit.

(2) A proposal subject to review under subsection (1) must be submitted to the ~~commission~~ COMMISSIONER at least 6 months before the first day of the next regular legislative session.

(3) After the ~~commission~~ COMMISSIONER has initiated ~~its~~ A review, ~~it~~ THE COMMISSIONER may request FROM THE ENTITY PRESENTING THE PROPOSAL FOR A MANDATED BENEFIT OR FROM ANY STATE AGENCY additional information that ~~it~~ THE COMMISSIONER considers necessary to complete ~~its~~ THE assessment of the proposal.

(4) The ~~commission~~ COMMISSIONER shall hold at least one public hearing during which the ~~applicant~~ ENTITY PRESENTING THE PROPOSAL FOR A MANDATED BENEFIT and members of the public have an opportunity to testify. The ~~commission~~ COMMISSIONER may consider more than one proposal at a public hearing. THE ADVISORY COUNCIL REQUIRED BY [SECTION 4] SHALL ATTEND THE HEARING AND ADVISE THE COMMISSIONER CONCERNING THE MATTERS CONTAINED IN THE PROPOSAL SUBMITTED TO THE COMMISSIONER.

(5) The ~~commission~~ COMMISSIONER shall prepare and, as provided in 5-11-210, submit a report to the legislature for its next regular session. The report must include but is not

limited to the ~~commission's~~ COMMISSIONER'S recommendation as to whether the proposal merits consideration by the legislature. If the ~~commission~~ COMMISSIONER declines to recommend a proposal, the ~~commission~~ COMMISSIONER shall state in ~~its~~ THE report the reasons for ~~its~~ THE action. The report to the legislature may include more than one proposal review.

~~(6) The legislature may not consider a proposal to mandate a new health insurance benefit or to repeal or amend an existing mandated benefit unless the commission certifies no later than December 31 preceding the beginning of a regular session that the proposal has been reviewed.~~

NEW SECTION. **Section 4.** ~~Meetings -- compensation -- staff assistance.~~ ~~(1) The commission shall meet when sufficient requests for reviews of proposals have been received or not later than the first day of August of the year preceding a regular session of the legislature, unless no requests have been received.~~

~~(2) Members of the commission are entitled to expenses as provided in 2-18-501 through 2-18-503.~~

~~(3) The commissioner of insurance and the department of health and environmental sciences shall provide staff assistance to the commission.~~ ADVISORY COUNCIL -- MEMBERSHIP -- COMPENSATION -- MEETINGS. (1) THE COMMISSIONER SHALL APPOINT AN ADVISORY COUNCIL TO ADVISE THE COMMISSIONER

CONCERNING THE DUTIES OF THE COMMISSIONER UNDER [SECTION 3]. THE COUNCIL CONSISTS OF EIGHT MEMBERS. THE DIRECTOR OF HEALTH AND ENVIRONMENTAL SCIENCES OR THE DIRECTOR'S DESIGNEE IS AN EX OFFICIO MEMBER. THE OTHER SEVEN MEMBERS MUST BE APPOINTED BY THE COMMISSIONER AS FOLLOWS:

(A) ONE REPRESENTATIVE OF THE GENERAL PUBLIC WHO IS NOT EMPLOYED IN THE INSURANCE INDUSTRY OR IN THE PROVISION OF HEALTH CARE AND WHO IS NOT AN OFFICER OR EMPLOYEE OF A LABOR ORGANIZATION;

(B) ONE ADMINISTRATOR OF A HEALTH CARE FACILITY, AS DEFINED IN 50-5-101;

(C) ONE HEALTH CARE PROVIDER WHO IS NOT ACTIVELY EMPLOYED IN THE MENTAL HEALTH, MENTAL ILLNESS, OR ADDICTIVE DISEASE TREATMENT FIELD;

(D) ONE LICENSED OR CERTIFIED MENTAL HEALTH, MENTAL ILLNESS, OR ADDICTIVE DISEASE CARE PROVIDER;

(E) ONE EMPLOYER WHO IS NOT ACTIVE IN THE HEALTH CARE OR INSURANCE FIELD;

(F) ONE REPRESENTATIVE OF A COLLECTIVE BARGAINING LABOR ORGANIZATION; AND

(G) ONE REPRESENTATIVE OR LICENSED INSURANCE PRODUCER OF A COMPANY OR ORGANIZATION LICENSED TO PROVIDE DISABILITY INSURANCE IN MONTANA.

(2) EACH COUNCIL MEMBER APPOINTED BY THE COMMISSIONER SHALL SERVE A ~~4-YEAR~~ 2-YEAR TERM; ~~EXCEPT THAT THE~~

~~COMMISSIONER SHALL DESIGNATE FOUR OF THE INITIAL MEMBERS TO SERVE 4-YEAR TERMS AND THREE TO SERVE 2-YEAR TERMS~~. A MEMBER APPOINTED TO FILL A VACANCY SHALL SERVE UNTIL THE END OF THAT TERM.

(3) THE COUNCIL SHALL ELECT ONE OF ITS MEMBERS AS PRESIDING OFFICER AND ONE AS VICE PRESIDING OFFICER.

(4) EXCEPT AS PROVIDED IN THIS SECTION, THE COUNCIL MUST BE APPOINTED, COMPENSATED, REIMBURSED, AND ADMINISTERED AS PROVIDED IN 2-15-122.

(5) THE COUNCIL SHALL MEET AT THE TIME REQUIRED BY [SECTION 3(4)] AND AT OTHER TIMES AS REQUESTED BY THE COMMISSIONER.

NEW SECTION. **Section 5.** **Contents of proposal.** The proposal ~~submitted by the applicant~~ FOR THE MANDATED BENEFIT must include but is not limited to the following information, to the extent that it is available:

(1) the social impact of mandating the benefit, including:

(a) the extent to which the treatment or service is used by a significant portion of the population;

(b) the extent to which the treatment or service is available to the population;

(c) the extent to which insurance coverage for this treatment or service is already available;

(d) if coverage is not generally available, the extent

to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(e) if coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(f) the level of public demand and the level of demand from health care providers for the treatment or service;

(g) the level of public demand and the level of demand from health care providers for individual or group insurance coverage of the treatment or service;

(h) the level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts;

(i) the likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(j) the relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit;

(k) the alternatives to meeting the identified need;

(l) whether the benefit is a medical need or a broader social need and whether it is consistent with the role of health insurance;

(m) the impact on the market of any social stigma attached to the benefit;

(n) the impact of this benefit on the availability of other benefits currently being offered; and

(o) the impact of the benefit as it relates to employers shifting to self-insured plans;

(2) the financial impact of mandating the benefit, including:

(a) the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years;

(b) the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years;

(c) the extent to which the mandated benefit might serve as an alternative for more expensive or less expensive treatment or service;

(d) the methods that will be instituted to manage the use and costs of the proposed mandated benefit;

(e) the extent to which the insurance coverage may affect the number and types of providers of the mandated benefit over the next 5 years;

(f) the extent to which the insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(g) the impact of indirect costs, which are costs other

than premiums and administrative costs, on the question of the costs and benefits of coverage;

(h) the impact of this coverage on the total cost of health care; and

(i) the effects on the cost of health care to employers and employees, including the financial impact on small businesses, medium-sized businesses, and large businesses;

(3) the medical efficacy of mandating the benefit, including:

(a) the contribution of the benefit to the quality of patient care and the health status of the population, such as the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or to not providing the treatment or service; and

(b) if the legislation seeks to mandate coverage of an additional class of practitioners:

(i) the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

(ii) the methods used by the appropriate professional organization to ensure clinical proficiency;

(4) the effects of balancing the social, economic, and medical efficacy considerations, including:

(a) the extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders; and

(b) the extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders.

Section 6. Section 5-11-210, MCA, is amended to read:

"5-11-210. Clearinghouse for reports to legislature. (1) For the purposes of this section, "report" means:

(a) a document required to be prepared for the legislature as required in any of the sections listed in subsection (10); and

(b) unless otherwise provided by law, any other report required by law to be given to or filed with the legislature.

(2) On or before September 1 of each year preceding the convening of a regular session of the legislature, an entity required to report to the legislature shall provide, in writing, to the executive director of the legislative council:

(a) the final title of the report;

(b) an abstract or description of the contents of the report, not to exceed one page;

(c) a recommendation on how many copies of the report should be provided to the legislature;

(d) the reasons why the number of copies recommended is, in the opinion of the reporting entity, the appropriate number of copies;

(e) an estimated cost for each copy of the report; and

(f) the date on which the entity will deliver the final, published copies of the report to the legislature.

(3) After considering all of the information available about the report, including the number of legislators requesting copies of the report pursuant to subsection (7), the legislative council or the executive director shall, in writing, direct the reporting entity to provide a specific number of copies. The number of copies required is at the sole discretion of the legislative council. The legislative council or the executive director may require the reporting entity to mail the copies of the report.

(4) The legislative council may require that the report be submitted in an electronic format useable on the legislature's current computer hardware, in a microform, such as microfilm or microfiche, or in a CD-ROM format, meaning compact disc read-only memory.

(5) Costs of preparing and distributing a report to the legislature, including writing, printing, postage, distribution, and all other costs, accrue to the reporting agency. Costs incurred in meeting the requirements of this section may not accrue to the legislative council.

(6) The executive director of the legislative council shall cause to be prepared a list of all reports required to be presented to the legislature from the list of titles received under subsection (2).

(7) The executive director shall, as soon as possible following a general election, mail to each holdover senator, senator-elect, and representative-elect a list of the titles of the reports, along with the abstracts prepared pursuant to subsection (2)(b), available from the legislative council. The list must include a form on which each member or member-elect receiving the list may indicate the report or reports that the member or member-elect would like to receive.

(8) The executive director or the legislative council shall make copies of reports requested pursuant to subsection (7) available to those members or members-elect by either requiring that copies be mailed pursuant to subsection (3) or by delivering copies of the reports during the first week of the legislative session.

(9) The executive director of the legislative council may keep as many copies of a report as he considers necessary, and copies of the report may be discarded at his discretion.

(10) (a) A report to the legislature includes a report required to be made by a board, bureau, commission,

committee, council, department, division, fund, authority, or officer of the state or a local government in 1-11-204, 2-4-411, 2-7-104, 2-8-112, 2-8-203, 2-8-207, 2-8-208, 2-15-2021, 2-18-209, 2-18-811, 2-18-1103, 3-1-702, 3-1-1126, 5-5-216, 5-13-304, 5-17-103, 5-18-203, 5-19-108, 10-4-102, 15-1-205, 17-4-107, 17-5-1650, 18-7-303, 19-4-201, 20-9-346, 20-25-236, 20-25-301, 22-3-107, 23-7-203, [section 3], 33-22-1513, 37-1-106, 39-6-101, 39-51-407, 44-2-304, 44-13-103, 46-23-316, 53-2-1107, 53-6-110, 53-20-104, 53-21-104, 53-24-204, 53-24-210, 53-30-133, 69-1-404, 72-16-202, 75-1-203, 75-1-1101, 75-7-304, 75-10-533, 75-10-704, 76-11-203, 76-12-109, 80-7-713, 80-12-402, 82-11-161, 85-1-621, 85-2-105, 87-2-724, 87-5-123, 90-3-203, or 90-4-111.

(b) The procedure outlined in this section may also be used for a report required to be made to the legislature under the Multistate Tax Compact contained in 15-1-601, the Vehicle Equipment Safety Compact contained in 61-2-201, the Multistate Highway Transportation Agreement contained in 61-10-1101, or the Western Interstate Nuclear Compact contained in 90-5-201."

NEW SECTION. **Section 7.** Appropriation. There is appropriated for the biennium ending June 30, 1995, $11,000 from the general fund to the commissioner of insurance for use by the ~~commission~~ COMMISSIONER to review mandated

benefits ~~established in [section 2]~~.

NEW SECTION. **Section 8.** Effective date. [This act] is effective July 1, 1993.

NEW SECTION. **SECTION 9.** TERMINATION. [THIS ACT] TERMINATES JANUARY 1, 1995.

-End-