

SENATE BILL 285

Introduced by Franklin, et al.

2/01 Introduced
2/01 Referred to Public Health, Welfare & Safety
2/01 First Reading
2/01 Fiscal Note Requested
2/10 Hearing
2/10 Fiscal Note Received
2/10 Fiscal Note Printed
2/20 Committee Report--Bill Passed as Amended
2/22 2nd Reading Passed
2/23 3rd Reading Passed

Transmitted to House
2/23 Referred to Human Services & Aging
2/23 First Reading
3/02 Revised Fiscal Note Requested
3/11 Revised Fiscal Note Received
3/13 Revised Fiscal Note Printed
3/24 Hearing
3/30 Committee Report--Bill Concurred as Amended
3/30 On Motion Rules Suspended to Allow on
2nd and 3rd Reading Tomorrow
3/31 2nd Reading Concurred
4/01 3rd Reading Concurred

Returned to Senate with Amendments
4/06 2nd Reading Amendments Not Concurred
4/07 Conference Committee Appointed
4/21 Conference Committee Report No. 1
4/22 2nd Reading Conference Committee
Report No. 1 Adopted
4/22 3rd Reading Conference Committee
Report No. 1 Adopted

House
4/13 Conference Committee Appointed
4/21 Conference Committee Report No. 1
4/22 2nd Reading Conference Committee
Report No. 1 Adopted

4/22 3rd Reading Conference Committee
Report no. 1 Adopted

4/28 Signed by President
4/28 Signed by Speaker
4/28 Transmitted to Governor
5/03 Signed by Governor
Chapter Number 606
Effective Date: 05/03/93--Sections 1-20,
& 44-47
Effective Date: 07/01/93--Sections 30-34
Effective Date: 10/01/93--Sections 29,
37-43
Effective Date: 01/01/94--Sections 22-28,
& 35-36
Effective Date: 07/01/96--Section 21

1 *Sen. Smith* BILL NO. *255* *Perkins* *W. Ryan* *Hallgren*
 2 INTRODUCED BY *Franklin B. Brown* *Jacobsen* *Schae*
 3 *W. V. Vetter* *MERCER* *Coppe* *Spencer* *Gring* *Cobb* *W. Ryan*
 4 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
 5 HEALTH CARE ACCESS, HEALTH CARE PLANNING AND COST
 6 CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
 7 PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;
 8 REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;

9 REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING
 10 FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;
 11 REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON
 12 LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH
 13 PLANNING REGIONS AND BOARDS; PROVIDING FOR THE POWERS AND
 14 DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
 15 UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR HEALTH
 16 INSURANCE REFORM; TRANSFERRING TO THE AUTHORITY CERTAIN
 17 FUNCTIONS OF THE DEPARTMENT AND BOARD OF HEALTH AND
 18 ENVIRONMENTAL SCIENCES RELATING TO VITAL STATISTICS;
 19 AMENDING SECTION 50-15-101, MCA; AND PROVIDING EFFECTIVE
 20 DATES."

STATEMENT OF INTENT

23 A statement of legislative intent is required for this
 24 bill because [section 10] requires the Montana health care
 25 authority to adopt rules establishing a maximum of five

1 health care planning regions, to establish regional health
 2 care planning boards within those regions, and to establish
 3 a procedure for selection of regional board members. The
 4 legislature intends that the rules establishing the health
 5 care planning regions be based primarily upon the geographic
 6 health care referral patterns by which health care providers
 7 refer patients to specialists or larger health care
 8 facilities. These rules should also consider communication
 9 and transportation patterns and natural barriers to these
 10 patterns. The rules establishing the boards must specify the
 11 number of members, any relevant qualifications, and the
 12 operations and duties of the boards and must provide for a
 13 funding mechanism by grant from the authority. The procedure
 14 for selection of the board members must provide for public
 15 notice of the selection process.

16 A statement of intent is also required because [section
 17 12] requires the authority to adopt rules relating to the
 18 unified health care data base. The authority's rules must
 19 specify in comprehensive detail what information is required
 20 to be provided by health care providers and the times at
 21 which the information is to be provided. The rules must also
 22 provide for audit procedures to determine the accuracy of
 23 the filed data. The confidentiality provisions must be
 24 consistent with other state laws governing the
 25 confidentiality of public records, including medical

records, and must apply to employees of the authority and to others receiving or using records in the data base.

A statement of intent is also required because [section 13] requires the commissioner of insurance to adopt rules governing small employer group health plans. In determining the basic benefits package, the commissioner shall make objective determinations, supported by available data, concerning the type of benefits required and shall determine that the benefits to be required are cost-effective.

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

NEW SECTION. Section 1. Montana health care authority
-- allocation -- **membership.** (1) There is a Montana health care authority.

(2) The authority is allocated to the department of health and environmental sciences for administrative purposes as provided in 2-15-121.

(3) The authority consists of five voting members appointed by the governor as follows:

(a) Within 30 days of [the effective date of this section], the majority and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment

to the authority.

(b) Within 30 days of [the effective date of this section], the majority and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(c) Within 90 days of [the effective date of this section], the governor shall appoint from those nominated under subsections (3)(a) and (3)(b) five individuals to the authority.

(4) A vacancy must be filled in the same manner as original appointments under subsection (3), except that one individual must be selected under subsection (3)(a) and one under subsection (3)(b). The governor shall appoint from those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and

1 rehabilitation services and the department of health and
2 environmental sciences are nonvoting, ex-officio members of
3 the authority.

4 **NEW SECTION. Section 2. Definitions.** For the purposes
5 of [sections 2 through 13], the following definitions apply:

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

8 (2) "Board" means one of the regional health care
9 planning boards created pursuant to [section 10].

10 (3) "Data base" means the unified health care data base
11 created pursuant to [section 12].

12 (4) "Health care facility" means all facilities and
13 institutions, whether public or private, proprietary or
14 nonprofit, that offer diagnosis, treatment, and inpatient or
15 ambulatory care to two or more unrelated persons. The term
16 includes all facilities and institutions included in
17 50-5-101(19). The term does not apply to a facility operated
18 by religious groups relying solely on spiritual means,
19 through prayer, for healing.

20 (5) "Health insurer" means any health insurance
21 company, health maintenance organization, insurer providing
22 disability insurance as described in 33-1-207, and, to the
23 extent permitted under federal law, any administrator of an
24 insured, self-insured, or publicly funded health care
25 benefit plan offered by public and private entities.

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

5 (7) "Management plan" means the health care resource
6 management plan required by [section 6].

7 (8) "Region" means one of the health care planning
8 regions created pursuant to [section 10].

9 (9) "Statewide plan" means one of the statewide
10 universal health care access plans for access to health care
11 required by [section 4].

12 **NEW SECTION. Section 3. Administration of health care**
13 **authority -- reports -- compensation.** (1) The authority
14 shall employ a full-time executive director who shall
15 conduct or direct the daily operation of the authority. The
16 executive director is exempt from the application of
17 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through
18 2-18-1013 and serves at the pleasure of the authority. The
19 executive director shall prepare plans and options for
20 consideration by the authority and implement plans as
21 directed by the authority.

22 (2) The authority may employ professional and support
23 staff necessary for the conduct of the business of the
24 authority and the business of the boards and may employ
25 consultants for the provision of services necessary to

fulfill the duties of the authority under [sections 2 through 13].

(3) The authority shall report to the legislature and the governor at least twice a year on its progress since the last report in fulfilling the requirements of [sections 2 through 13]. Reports may be provided in a manner similar to 5-11-210 or in another manner determined by the authority.

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

(5) The authority shall make grants to the boards for the operation of the boards. The authority shall provide for uniform procedures for grant applications and budgets of the boards.

NEW SECTION. Section 4. Statewide universal health care access plans required. On or before October 1, 1994, the authority shall submit a report to the legislature that contains the authority's recommendation for a statewide universal health care access plan based on a single payor concept and a recommendation for a statewide universal access plan based on a regulated multiple payor concept. Each statewide plan must guarantee access to health care services for residents of Montana by making available a uniform system of health care benefits. Each statewide plan must contain the features required by this section and [sections 5 through 8].

NEW SECTION. Section 5. Cost containment. (1) The statewide plans must contain a cost containment component. Except as otherwise provided in this section, each statewide plan must establish a target for cost containment so that by 1999, the annual average percentage increase in statewide health care costs does not exceed the average annual percentage increase in the gross domestic product, as determined by the U.S. department of commerce, for the 5 preceding years.

(2) The authority may modify the target required in subsection (1) to take into account such factors as population increases or decreases, demographic changes, costs beyond the control of health care providers, and other factors that the authority considers significant.

(3) The authority shall include the following features in the cost containment component:

(a) global budgeting for all health care spending;

(b) a system for limiting demand of health care services and controlling unnecessary and inappropriate health care. The system may include prioritization of services that allows for consideration of an individual patient's prognosis.

(c) a system for reimbursing health care providers for services and health care items. The reimbursement system must provide that all payors, public or private, pay the

1 same rate for the same health care services and items and
2 that reimbursement for services is based predominantly upon
3 the health care service provided rather than upon the
4 discipline of the health care provider.

5 (d) a method of monitoring compliance with the target
6 required in subsection (1);

7 (e) expenditure targets for health care providers;

8 (f) disincentives for exceeding the targets established
9 pursuant to subsection (3)(e), including reduction of
10 reimbursement levels in subsequent years;

11 (g) reimbursement of health care providers and health
12 care facilities that is based upon negotiated annual budgets
13 or fees for services; and

14 (h) a plan by the authority, health care providers, and
15 health care facilities to educate the public concerning the
16 purpose and content of the statewide plans.

17 **NEW SECTION. Section 6. Health care resource**
18 **management plan.** (1) Each statewide plan must contain a
19 health care resource management plan. The management plan
20 must provide for the distribution of health care resources
21 within the regions established pursuant to [section 10] and
22 within the state as a whole, consistent with the principles
23 provided in subsection (2).

24 (2) The management plan must:

25 (a) be prepared by the authority after consideration of

1 regional management plans submitted to the authority
2 pursuant to [section 11];

3 (b) allow the authority to address individual needs of
4 each region, including such matters as the needs of Indian
5 tribes within the region, population increases or decreases,
6 and other demographic factors that the authority considers
7 significant;

8 (c) include incentives to improve access to health care
9 in underserved areas, including:

10 (i) a system by which the authority may identify
11 persons with an interest in becoming health care
12 professionals and provide or assist in providing health care
13 education for those persons; and

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

17 (d) include incentives to improve access to and use of
18 preventive care; primary care services, including mental
19 health services; and community-based care;

20 (e) include incentives for healthy lifestyles; and

21 (f) be biennially reviewed by the authority and be
22 amended as necessary.

23 **NEW SECTION. Section 7. Health care billing**
24 **simplification.** (1) Each statewide plan must contain a
25 component providing for simplification and reduction of the

costs associated with health care billing. In designing this component, the authority may consider:

(a) conversion from paper health care claims to standardized electronic billing;

(b) creating a claims clearinghouse, consisting of a state agency or private entity, to receive claims from all health care providers for compiling, editing, and submitting the claims to payors; and

(c) requiring use of uniform claim forms and uniform reporting of health care information.

(2) The health care billing component must include a method to educate and assist health care providers and payors who will use any health care billing simplification system recommended by the authority.

(3) The billing component must provide a schedule for a phasein of any health care billing simplification system recommended by the authority. The schedule must relieve health care providers, payors, and consumers of undue burdens in using the system.

NEW SECTION. Section 8. Other matters to be included in statewide plans. (1) The statewide plans recommended by the authority must include:

(a) stable financing methods, including sharing of the costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments

or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phasein of the various components of the plans.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

(i) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

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

(b) As part of its study, the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be included in its report containing the statewide plans.

(3) The authority shall conduct a study of the impacts of federal and state antitrust laws on health care services in the state and make recommendations, including legislation, to address those laws and impacts. The authority shall include in its plans legislation that will enable health care providers or consumers, or both, to

1 negotiate and enter into agreements when the agreements are
2 likely to result in lower costs or in greater access or
3 quality than would otherwise occur in the competitive
4 marketplace. In proposing appropriate legislation concerning
5 antitrust laws, the authority shall provide appropriate
6 conditions, supervision, and regulation to protect against
7 private abuse of economic power.

8 (4) The authority shall apply for waivers from federal
9 laws necessary to implement recommendations of the authority
10 enacted by the legislature and to implement those
11 recommendations not requiring legislation.

12 NEW SECTION. Section 9. Long-term care study and
13 recommendations. The authority shall conduct a study of the
14 long-term care needs of state residents and report to the
15 public and the legislature the authority's recommendations,
16 including any necessary legislation, for meeting those
17 long-term care needs. The report must be available to the
18 public on or before September 1, 1996, after which the
19 authority shall conduct public hearings on its report in
20 each region established under [section 10]. The authority
21 shall present its report to the legislature on or before
22 January 1, 1997.

23 NEW SECTION. Section 10. Health care planning regions
24 and regional planning boards created -- selection --
25 membership. (1) The authority shall by rule establish within

1 the state a maximum of five health care planning regions
2 that consist of counties or parts of counties, or both.
3 Regions must be established based principally upon the
4 geographic health care patterns of referral by which health
5 care providers refer patients to specialists of health care
6 facilities for more complex care. Each area of the state
7 must be part of a region.

8 (2) Within each region, the board shall establish by
9 rule a regional health care planning board. Each board must
10 have five members and must include individuals who are
11 health care consumers and individuals who are recognized for
12 their interest or expertise, or both, in health care.

13 (3) The authority shall, within 30 days of appointment
14 of its members, propose by rule a procedure for selecting
15 members of boards. The authority shall select five members
16 for each board within 180 days of appointment of the
17 authority, using the selection procedure adopted by rule
18 under this subsection. Vacancies on a board must be filled
19 by using the authority's selection process.

20 (4) Regional board members serve 4-year terms, except
21 that of the board members initially selected, one member
22 serves for 2 years, two members serve for 3 years, and two
23 members serve for 4 years, to be determined by lot. A
24 majority of each regional board shall select a presiding
25 officer. The presiding officer initially selected must serve

1 a 4-year term. Board members must be compensated and
2 reimbursed in accordance with 2-15-124.

3 **NEW SECTION. Section 11. Duties of boards.** A board
4 shall:

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

7 (2) submit an annual budget and grant application to
8 the authority at the time and in the manner directed by the
9 authority;

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

13 (4) establish a process to determine health care needs
14 of the region;

15 (5) advise the authority concerning all health care
16 needs of the region relating to the creation and
17 implementation of the statewide plan;

18 (6) submit to the authority a regional management plan
19 providing for allocation of health care resources within the
20 region, including allocation of resources in underserved
21 areas;

22 (7) establish a mechanism for determining and
23 considering the health care needs of Indian tribes within
24 the region; and

25 (8) conduct at least one annual public hearing to

1 provide for public participation in the development of the
2 regional management plan.

3 **NEW SECTION. Section 12. Health care data base --**
4 **information submitted -- enforcement.** (1) The authority
5 shall develop and maintain a unified health care data base
6 that enables the authority, on a statewide basis, to:

7 (a) determine the distribution and capacity of health
8 care resources, including health care facilities, providers,
9 and health care services;

10 (b) identify health care needs and direct statewide and
11 regional health care policy to ensure high-quality and
12 cost-effective health care;

13 (c) conduct evaluations of health care procedures and
14 health care protocols; and

15 (d) compare costs of various health care procedures in
16 one location of providers and health care facilities with
17 the costs of the same procedures in other locations of
18 providers and health care facilities.

19 (2) The authority shall by rule require health care
20 providers, health insurers, and health care facilities,
21 private entities, and entities of state and local
22 governments to file with the authority the reports, data,
23 schedules, statistics and other information determined by
24 the authority to be necessary to fulfill the purposes of the
25 data base provided in subsection (1). Material to be filed

1 with the authority may include health insurance claims and
2 enrollment information used by health insurers.

3 (3) The authority may issue subpoenas for the
4 production of information required under this section and
5 may issue subpoenas for and administer oaths to any person.
6 Noncompliance with a subpoena issued by the authority is,
7 upon application by the authority, punishable by a district
8 court as contempt pursuant to Title 3, chapter 1, part 5.

9 (4) The data base must:

10 (a) use unique patient and provider identifiers and a
11 uniform coding system identifying health care services; and

12 (b) reflect all health care utilization, costs, and
13 resources in the state and the health care utilization and
14 costs of services provided to Montana residents in another
15 state.

16 (5) Information in the data base required by law to be
17 kept confidential must be maintained in a manner that does
18 not disclose the identity of the person to whom the
19 information applies.

20 (6) The authority shall adopt by rule a confidentiality
21 code to ensure that information in the data base is
22 maintained and used according to state law governing
23 confidential health care information.

24 (7) The duties of the authority under this section may
25 not be construed to allow the authority to use the data base

1 to manage a corporate health care facility in a manner that
2 usurps the appropriate powers of the board of directors of
3 the facility.

4 NEW SECTION. **Section 13. Small employer group health**
5 **insurance reform.** (1) As used in this section, the following
6 definitions apply:

7 (a) "Health plan" or "plan" means the plan specified in
8 the rules adopted pursuant to subsection (2).

9 (b) "Person" means an individual, corporation, firm,
10 partnership, sole proprietorship, or other business entity.

11 (c) "Small employer" means a person employing at least
12 3 but not more than 25 employees.

13 (2) The commissioner of insurance shall adopt rules
14 specifying the health care benefits to be included in health
15 care plans offered by small employers.

16 (3) A health insurer who offers a health plan to a
17 small employer in Montana shall offer the same health plan
18 to other small employers in Montana and shall allow
19 continuous open enrollment in that plan.

20 (4) A health insurer who offers a health plan may not
21 limit preexisting conditions for a period longer than 6
22 months after the effective date of coverage under the plan.

23 (5) A health insurer may not cancel, refuse to issue,
24 or refuse to renew coverage under a health plan for any
25 reason other than nonpayment of premiums or fraud or

1 material misrepresentation by the insured in the application
2 for coverage under the plan.

3 (6) A health insurer shall provide notice to an insured
4 of the terms of renewal of coverage under a health plan at
5 least 10 days before the expiration of the coverage. The
6 terms upon which coverage under the plan is offered to the
7 insured for renewal may not be any less favorable, with
8 respect to all provisions, including benefits but excluding
9 premium rates and minor administrative changes, than the
10 terms of the coverage about to expire.

11 (7) A health insurer may not charge a higher premium
12 for renewal of coverage under a health plan than for initial
13 coverage under the same plan.

14 (8) A health insurer shall renew coverage under a
15 health plan for not less than 12 months.

16 (9) A health insurer may not require an insured or a
17 person applying for coverage under a health plan with that
18 insurer to comply with limitations in a health plan
19 concerning preexisting conditions if that insured or person
20 has previously satisfied preexisting condition requirements
21 of another health insurance policy or plan offering
22 substantially similar benefits.

23 (10) Except as provided in subsection (11), all health
24 insurers shall establish a single rating scheme that is
25 applied consistently for health plans and does not

1 discriminate between persons as to the amount of the premium
2 based upon differences in sex, health status, employment, or
3 geographic location.

4 (11) (a) The commissioner of insurance shall adopt by
5 rule standards and a procedure to allow health insurers to
6 use one or more risk classifications in establishing their
7 rating system. The rating system may not contain a rate
8 spread greater than 30% of the median rate or less than 30%
9 of the median rate.

10 (b) The commissioner shall phase in the requirements of
11 subsection (10) and this subsection as the commissioner
12 considers appropriate.

13 (c) By July 1, 1995, a premium rate may not exceed 125%
14 of the premium rate for the least expensive group.

15 (12) On [6 months from the effective date of this
16 subsection] the commissioner of insurance shall adopt rules
17 implementing this section. The rules adopted by the
18 commissioner become effective on [1 year from the effective
19 date of this subsection].

20 NEW SECTION. **Section 14.** Vital statistics transferred
21 to authority. (1) The functions of the board of health and
22 environmental sciences and the department of health and
23 environmental sciences contained in Title 50, chapter 15,
24 concerning vital statistics are transferred to the Montana
25 health care authority created in [section 1].

(2) The code commissioner shall change references to "department of health and environmental sciences" or "department" (of health and environmental sciences) and "board of health and environmental sciences" or "board" (of health and environmental sciences) to "authority" and shall make other changes in grammar consistent with the purpose of this section.

Section 15. Section 50-15-101, MCA, is amended to read:

"50-15-101. Definitions. Unless the context requires otherwise, in parts 1 through 4 the following definitions apply:

(1) "Board Authority" means the ~~board--of--health--and environmental--sciences~~ Montana health care authority provided for in ~~2-15-2104~~ [section 1].

(2) "Dead body" means a lifeless human body or parts of a body from which it reasonably may be concluded that death occurred recently.

~~(3)--"Department"--means--the--department--of--health--and environmental--sciences--provided--for--in--Title--2--chapter--15--part--21--~~

~~(4)(3)~~ "Dissolution of marriage" means a marriage terminated pursuant to Title 40, chapter 4, part 1.

~~(5)(4)~~ "Fetal death" means a birth after 20 weeks of gestation, or before 20 weeks of gestation if the fetus weighs more than 500 grams at the time of delivery, that is

not a live birth.

~~(6)(5)~~ "Invalid marriage" means a marriage decreed by a district court to be invalid for the reasons contained in 40-1-402.

~~(7)(6)~~ "Live birth" means the birth of a child who shows evidence of life after being entirely outside the mother.

~~(8)(7)~~ "Local registrar" means a person appointed by the department to act as its agent in administering this chapter in the area set forth in the letter of appointment.

~~(9)(8)~~ "Person in charge of interment" means a person who places or causes to be placed a dead body or the ashes after cremation in a grave, vault, urn, or other receptacle or otherwise disposes of the body.

~~(10)(9)~~ "Physician" means a person legally authorized to practice medicine in this state.

~~(11)(10)~~ "Vital statistics" includes the registration, preparation, transcription, collection, compilation, and preservation of data pertaining to births, adoptions, legitimations, deaths, fetal deaths, marital status, and incidental supporting data."

NEW SECTION. **Section 16.** Effective dates. (1) [Sections 1 through 12, 13(10) through (12), 14, 15, and this section] are effective on passage and approval.

(2) [Section 13(1) through (9)] is effective [1 year

1 from the date of passage and approval of this act].

2 NEW SECTION. **Section 17.** Codification instruction. (1)

3 [Section 1] is intended to be codified as an integral part
4 of Title 2, chapter 15, and the provisions of Title 2,
5 chapter 15, apply to [section 1].

6 (2) [Sections 2 through 13] are intended to be codified
7 as an integral part of Title 50, and the provisions of Title
8 50 apply to [sections 2 through 13].

-End-

STATE OF MONTANA - FISCAL NOTE

Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB0285, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION: An act providing for universal health care access, health care planning and cost containment; creating the Montana Health Care Authority, providing for the powers and duties of the authority; requiring a statewide universal health care access plan; requiring a health care resource management plan; providing for simplification of health care expenses billing; requiring the authority to conduct a study and report on long-term care; requiring the authority to establish health planning regions and boards; providing for the powers and duties of regional boards; requiring the establishment of a unified health care data base; providing for health insurance reform; and transferring to the authority certain functions of the department and board of health and environmental sciences relating to vital statistics.

ASSUMPTIONS:

Montana Health Care Authority

1. During the 1995 biennium, the Montana Health Care Authority (MHCA) will focus predominately on development of a health care database, analysis of patterns of health care utilization and cost, policy development, and development of specific health plans for presentation to the 1995 legislative session.
2. Development of the organization structure necessary to fulfill the responsibilities of the MHCA will occur as soon as possible after passage of the bill. The executive director and board secretary will be hired as soon as possible upon passage.
3. Due to the complexity of health care issues, the MHCA will require significant technical assistance on a wide variety of issues impacting the different sectors of health care including the general field of medicine, health care reform, legal ramifications of medical malpractice issues, substantial actuarial data collection and analysis, medical technology, and complex health data system. In order to give the MHCA the flexibility to analyze the staffing needs of the Authority and identify those services that could most efficiently be provided through contracts, the majority of funds are allocated to operating expenses with the understanding that the MHCA would have the option to hire such staff as deemed necessary and appropriate.
4. The five appointed members of the Health Care Authority serve as volunteers and are not state employees.
5. There will be five regional boards. All regional board members are volunteers and are not state employees.
6. The MHCA and regional boards will conduct at least six meetings per year during the first two years.
7. Travel and per diem for regional boards is included in the operating expenses of the MHCA.
8. It is anticipated that grant funds from the Robert Wood Johnson Foundation will be available to assist the MHCA in the development of the statewide health care database.
9. To the extent that MHCA activities are directly related to the state's Medicaid program, such expenditures could be matched for federal funds at a ratio of 50% state and 50% federal funds.
10. The Vital Statistics Bureau will be transferred intact to the Health Care Authority. Existing bureau expenditures and revenues will remain, but are not included in this fiscal note. If the Vital Statistics Bureau were physically moved there would be costs related to that move we are unable to estimate.

(Continued)

Dave Lewis 2-9-93
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

EVE FRANKLIN, PRIMARY SPONSOR DATE
Fiscal Note for SB0285, as introduced

2/10/93
SB 285

State Auditor's Office

- 1. The Insurance Commissioner will adopt rules for benefit plans.
- 2. The Insurance Commissioner will review rates.
- 3. The Insurance Commissioner will adopt rules for risk classification and rating.
- 4. Staff will not be hired until the start of FY94 even though part of the bill's responsibilities are initiated upon passage and approval. Two FTE would be hired; one Grade 15 @ \$32,817/year and an actuary @ \$74,400/year.

FISCAL IMPACT:

<u>Montana Health Care Authority</u>	<u>FY '94</u>			<u>FY '95</u>		
	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>
FTE	0	2.00	2.00	0	2.00	2.00
Personal services	0	93,921	93,921	0	93,921	93,921
Operating expenses	0	656,079	656,079	0	656,079	656,079
Total	0	750,000	750,000	0	750,000	750,000

Expenditures:

General Fund*	0	750,000	750,000	0	750,000	750,000
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* Ignores potential use of federal and foundation funds per assumptions 8 and 9.

<u>State Auditor's Office</u>	<u>FY '94</u>			<u>FY '95</u>		
	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>	<u>Current Law</u>	<u>Proposed Law</u>	<u>Difference</u>
Personal Services	0	\$107,217	\$107,217	0	\$107,217	\$107,217
Operating Costs	0	35,600	35,600	0	35,600	35,600
Equipment	0	2,568	2,568	0	0	0
Total	0	\$145,385	\$145,385	0	\$142,817	\$142,817

Expenditures:

In order to implement this bill, additional general fund expenditures in the amount of \$145,385 and \$142,817 will be required in the coming biennium.

TECHNICAL NOTES:

Revenues and expenditures related to the Vital Records and Statistics Bureau will be incorporated into the Health Care Authority. These figures are not included under fiscal impact.

SB 285

STATE OF MONTANA - FISCAL NOTE

Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB0285, third reading.

DESCRIPTION OF PROPOSED LEGISLATION: An act providing for universal health care access, health care planning and cost containment; creating the Montana Health Care Authority, providing for the powers and duties of the authority; requiring a statewide universal health care access plan; requiring a health care resource management plan; providing for simplification of health care expenses billing; requiring the authority to conduct a study and report on long-term care; requiring the authority to establish health planning regions and boards; providing for the powers and duties of regional boards; requiring the establishment of a unified health care data base; providing for health insurance reform; and transferring to the authority certain functions of the department and board of health and environmental sciences relating to vital statistics.

ASSUMPTIONS:

Montana Health Care Authority

1. During the 1995 biennium, the Montana Health Care Authority (MHCA) will focus predominately on development of a health care database, analysis of patterns of health care utilization and cost, policy development, and development of specific health plans for presentation to the 1995 legislative session.
2. Development of the organization structure necessary to fulfill the responsibilities of the MHCA will occur as soon as possible after passage of the bill. The executive director and board secretary will be hired as soon as possible upon passage.
3. Due to the complexity of health care issues, the MHCA will require significant technical assistance on a wide variety of issues impacting the different sectors of health care including the general field of medicine, health care reform, legal ramifications of medical malpractice issues, substantial actuarial data collection and analysis, medical technology, and complex health data system. In order to give the MHCA the flexibility to analyze the staffing needs of the Authority and identify those services that could most efficiently be provided through contracts, the majority of funds are allocated to operating expenses with the understanding that the MHCA would have the option to hire such staff as deemed necessary and appropriate.
4. The five appointed members of the Health Care Authority serve as volunteers and are not state employees.
5. There will be five regional boards. All regional board members are volunteers and are not state employees.
6. The MHCA and regional boards will conduct at least six meetings per year during the first two years.
7. Travel and per diem for regional boards is included in the operating expenses of the MHCA.
8. It is anticipated that grant funds from the Robert Wood Johnson Foundation will be available to assist the MHCA in the development of the statewide health care database.
9. To the extent that MHCA activities are directly related to the state's Medicaid program, such expenditures could be matched for federal funds at a ratio of 50% state and 50% federal funds.
10. The Vital Statistics Bureau will be transferred intact to the Health Care Authority. Existing bureau expenditures and revenues will remain, but are not included in this fiscal note. If the Vital Statistics Bureau were physically moved there would be costs related to that move we are unable to estimate.

(Continued)

Dave Lewis 3-10-93
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Eve Franklin 3/13/93
EVE FRANKLIN, PRIMARY SPONSOR DATE
Fiscal Note for SB0285, third reading

SB 285.42

State Auditor's Office

11. The insurance commissioner will appoint a nine member Health Benefit Plan Committee July 1, 1993. They will conduct meetings and recommend a basic and standard plan by Dec 31, 1993. The commissioner will adopt plans by March 1, 1994.
12. The insurance commissioner will receive the required premium information from insurance companies by Sept 1, 1993 and will appoint a nine member reinsurance board by Sept 15, 1993. This board will submit an operational plan for reinsurance by March 15, 1994. The commissioner will adopt the plan by May 15, 1994.
13. The commissioner will adopt rules for rating practices and actuarial certification during FY94.
14. The commissioner will work with the Authority to design a uniform claim form (Section 10) and will adopt rules in FY95 to implement the form. Implementation will not occur during the 95 biennium.
15. The reinsurance plan will take effect July 1, 1994. The board will use its authority to borrow funds for initial operations and to cover claims. Assessments will be made against premiums in an amount necessary to pay off the loan. Therefore no general fund appropriation will be necessary to cover a loss or loan payment.

FISCAL IMPACT:

	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
<u>Montana Health Care Authority</u>						
FTE	0	2.00	2.00	0	2.00	2.00
Personal services	0	93,921	93,921	0	93,921	93,921
Operating expenses	0	656,079	656,079	0	656,079	656,079
Total	0	750,000	750,000	0	750,000	750,000

Funding:

General Fund*	0	750,000	750,000	0	750,000	750,000
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* Ignores potential use of federal and foundation funds per assumptions 8 and 9.

	FY '94			FY '95		
	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
<u>State Auditor's Office</u>						
FTE	0	2.00	2.00	0	2.00	2.00
Personal Services	0	107,217	107,217	0	107,217	107,217
Operating Costs	0	68,600	68,600	0	56,600	56,600
Equipment	0	2,568	2,568	0	0	0
Total	0	178,385	178,385	0	163,817	163,817

Funding:

General Fund	0	178,385	178,385	0	163,817	163,817
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TECHNICAL NOTES:

The effective date of sections 22-36 should be July 1, 1993 in order to meet other deadlines in the bill.

The reinsurance board needs statutory appropriation authority as provided in Section 17-7-502, M.C.A. in order to pay claims anticipated by creation of the reinsurance pool.

SB 285#2

APPROVED BY COMMITTEE
ON PUBLIC HEALTH, WELFARE
& SAFETY

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE,
BIANCHI, HARPER, JERGESON, RYAN, LYNCH, HALLIGAN,
VAN VALKENBURG, MERCER, CRIPPEN, SQUIRES, GRINDE, COBB,
CHRISTIAENS, BLAYLOCK, L. NELSON, ECK, STRIZICH, TOOLE,
COCCHIARELLA, MCCARTHY, WILSON, WATERMAN, BECK, KLAMPE,
DOWELL, RUSSELL, STANFORD, TUSS, DOLEZAL, DOHERTY,
PAVLOVICH, WEEDING, BRUSKI-MAUS, NATHE, VAUGHN,
WELDON, KENNEDY, WILSON, BARTLETT,
SIMPKINS, HOCKETT, YELLOWTAIL, J. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
HEALTH CARE ACCESS, HEALTH CARE PLANNING, AND COST
CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;
REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;
REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING
FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;
~~REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON~~
~~LONG-TERM CARE, REQUIRING THE AUTHORITY TO ESTABLISH HEALTH~~
~~PLANNING REGIONS AND BOARDS~~ REQUIRING DEVELOPMENT OF UNIFORM
CLAIM FORMS AND PROCEDURES; REQUIRING THE AUTHORITY TO
CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM
CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH
CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL

HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND
DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
UNIFIED HEALTH CARE DATA BASE; PROVIDING---FOR---HEALTH
INSURANCE---REFORM REQUIRING HEALTH INSURER COST MANAGEMENT
PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF
THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL
SCIENCES RELATING TO VITAL-STATISTICS STATE HEALTH PLANNING;
PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY
ACT; AMENDING SECTION 50-15-101 50-1-201, MCA; AND PROVIDING
EFFECTIVE DATES."

STATEMENT OF INTENT

~~A statement of legislative intent is required for this~~
~~bill because {section 10} requires the Montana health care~~
~~authority to adopt rules establishing a maximum of five~~
~~health care planning regions, to establish regional health~~
~~care planning boards within those regions, and to establish~~
~~a procedure for selection of regional board members. The~~
~~legislature intends that the rules establishing the health~~
~~care planning regions be based primarily upon the geographic~~
~~health care referral patterns by which health care providers~~
~~refer patients to specialists or larger health care~~
~~facilities. These rules should also consider communication~~
~~and transportation patterns and natural barriers to these~~
~~patterns. The rules establishing the boards must specify the~~

number--of--members,--any--relevant--qualifications,--and--the
operations--and--duties--of--the--boards--and--must--provide--for--a
funding--mechanism--by--grant--from--the--authority. The procedure
for--selection--of--the--board--members--must--provide--for--public
notice--of--the--selection--process.

A statement of intent is also required because--{section
12}--requires--the--authority--to--adopt--rules--relating--to--the
unified health care data base. The authority's--rules--must
specify in comprehensive detail what information is required
to--be--provided--by--health--care--providers--and--the--times--at
which the information is to be provided. The rules must also
provide for audit procedures to determine--the--accuracy--of
the--filed--data. The confidentiality provisions must be
consistent---with---other---state---laws---governing---the
confidentiality---of---public---records, including medical
records, and must apply to employees of the authority and to
others receiving or using records in the data base.

A statement of intent is also required because--{section
13}--requires--the--commissioner--of--insurance--to--adopt--rules
governing small employer group health plans. In determining
the--basic--benefits--package, the commissioner shall make
objective determinations, supported by available data,
concerning the type of benefits required and shall determine
that the benefits to be required are cost effective. A
STATEMENT OF LEGISLATIVE INTENT IS REQUIRED FOR THIS BILL

BECAUSE:

(1) [SECTION 4] AUTHORIZES THE MONTANA HEALTH CARE
AUTHORITY TO ADOPT RULES NECESSARY TO IMPLEMENT [SECTIONS 1
THROUGH 20]. IN ADDITION TO THOSE RULEMAKING MATTERS
ADDRESSED BELOW, THE AUTHORITY MAY ADOPT RULES GOVERNING
SUCH MATTERS AS ITS MEETINGS, PUBLIC HEARINGS, AND RULES OF
PROCEDURE AND RULES OF ETHICAL CONDUCT GOVERNING ITS
MEMBERS.

(2) [SECTION 17] REQUIRES THE MONTANA HEALTH CARE
AUTHORITY TO ADOPT RULES TO ESTABLISH REGIONAL HEALTH CARE
PLANNING BOARDS WITHIN THE HEALTH CARE PLANNING REGIONS
ESTABLISHED IN [SECTION 17] AND TO ESTABLISH A PROCEDURE FOR
SELECTION OF REGIONAL BOARD MEMBERS. THE RULES ESTABLISHING
THE BOARDS MUST SPECIFY THE NUMBER OF MEMBERS, ANY RELEVANT
QUALIFICATIONS, AND THE OPERATIONS AND DUTIES OF THE BOARDS
AND MUST PROVIDE FOR A FUNDING MECHANISM BY GRANT FROM THE
AUTHORITY. IN ADDITION, THE RULES MUST PROVIDE FOR
CONSIDERATION OF A BALANCE BETWEEN RURAL AND URBAN INTERESTS
IN THE SELECTION OF REGIONAL BOARD MEMBERS. THE PROCEDURE
FOR SELECTION OF THE BOARD MEMBERS MUST PROVIDE FOR PUBLIC
NOTICE OF THE SELECTION PROCESS.

(3) [SECTION 10] GRANTS THE COMMISSIONER OF INSURANCE
THE AUTHORITY TO ADOPT RULES SPECIFYING UNIFORM HEALTH
INSURANCE CLAIM FORMS AND PROCEDURES. THE FORMS SHOULD BE
BASED UPON EXISTING FORMATS, BE AS SHORT AS POSSIBLE, AND BE

1 COMPATIBLE WITH ELECTRONIC DATA TRANSMISSION.

2 (4) [SECTION 19] REQUIRES THE AUTHORITY TO ADOPT RULES
 3 RELATING TO THE UNIFIED HEALTH CARE DATA BASE. THE
 4 AUTHORITY'S RULES MUST SPECIFY IN COMPREHENSIVE DETAIL WHAT
 5 INFORMATION IS REQUIRED TO BE PROVIDED BY HEALTH CARE
 6 PROVIDERS AND THE TIMES AT WHICH THE INFORMATION IS TO BE
 7 PROVIDED. THE RULES MUST ALSO PROVIDE FOR AUDIT PROCEDURES
 8 TO DETERMINE THE ACCURACY OF THE FILED DATA. THE
 9 CONFIDENTIALITY PROVISIONS MUST BE CONSISTENT WITH OTHER
 10 STATE LAWS GOVERNING THE CONFIDENTIALITY OF PUBLIC RECORDS,
 11 INCLUDING MEDICAL RECORDS, AND MUST APPLY TO EMPLOYEES OF
 12 THE AUTHORITY AND TO OTHERS RECEIVING OR USING RECORDS IN
 13 THE DATA BASE.

14 (5) [SECTIONS 23, 26, 27, 30, AND 34 THROUGH 36]
 15 REQUIRE THE COMMISSIONER OF INSURANCE TO ADOPT RULES
 16 GOVERNING SMALL EMPLOYER GROUP HEALTH PLANS. IN DETERMINING
 17 THE BASIC BENEFITS PACKAGE, THE COMMISSIONER SHALL MAKE
 18 OBJECTIVE DETERMINATIONS, SUPPORTED BY AVAILABLE DATA,
 19 CONCERNING THE TYPE OF BENEFITS REQUIRED AND SHALL DETERMINE
 20 THAT THE BENEFITS TO BE REQUIRED ARE COST-EFFECTIVE PURSUANT
 21 TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE
 22 COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION
 23 PERIOD TO ALLOW SMALL EMPLOYER CARRIERS TO COMPLY WITH
 24 CERTAIN PROVISIONS OF THE ACT. THE COMMISSIONER MAY APPROVE
 25 THE ESTABLISHMENT OF ADDITIONAL CLASSES OF BUSINESSES ONLY

1 IF THE COMMISSIONER DETERMINES THAT THE ADDITIONAL CLASSES
 2 WOULD ENHANCE THE EFFICIENCY AND FAIRNESS OF THE SMALL
 3 EMPLOYER HEALTH INSURANCE MARKET. THE COMMISSIONER IS
 4 REQUIRED UNDER THE ACT TO ADOPT RULES TO IMPLEMENT AND
 5 ADMINISTER THE ACT.

6
 7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

8 (Refer to Introduced Bill)

9 Strike everything after the enacting clause and insert:

10 NEW SECTION. Section 1. State health care policy. (1)

11 It is the policy of the state of Montana to ensure that all
 12 residents have access to quality health services at costs
 13 that are affordable. To achieve this policy, it is necessary
 14 to develop a health care system that is integrated and
 15 subject to the direction and oversight of a single state
 16 agency. Comprehensive health planning through the
 17 application of a statewide health care resource management
 18 plan that is linked to a unified health care budget for
 19 Montana is essential.

20 (2) It is further the policy of the state of Montana
 21 that the health care system should:

22 (a) maintain and improve the quality of health care
 23 services offered to Montanans;

24 (b) contain or reduce increases in the cost of
 25 delivering services so that health care costs do not consume

1 a disproportionate share of Montanans' income or the money
2 available for other services required to ensure the health,
3 safety, and welfare of Montanans;

4 (c) avoid unnecessary duplication in the development
5 and offering of health care facilities and services;

6 (d) encourage regional and local participation in
7 decisions about health care delivery, financing, and
8 provider supply;

9 (e) promote rational allocation of health care
10 resources in the state; and

11 (f) facilitate universal access to preventive and
12 medically necessary health care.

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

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

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

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

21 (4) "Health care facility" means all facilities and
22 institutions, whether public or private, proprietary or
23 nonprofit, that offer diagnosis, treatment, and inpatient or
24 ambulatory care to two or more unrelated persons. The term
25 includes all facilities and institutions included in

1 50-5-101(19). The term does not apply to a facility operated
2 by religious groups relying solely on spiritual means,
3 through prayer, for healing.

4 (5) "Health insurer" means any health insurance
5 company, health service corporation, health maintenance
6 organization, insurer providing disability insurance as
7 described in 33-1-207, and, to the extent permitted under
8 federal law, any administrator of an insured, self-insured,
9 or publicly funded health care benefit plan offered by
10 public and private entities.

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

15 (7) "Management plan" means the health care resource
16 management plan required by [section 8].

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

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

22 NEW SECTION. Section 3. Montana health care authority
23 -- allocation -- membership. (1) There is a Montana health
24 care authority.

25 (2) The authority is allocated to the department of

health and environmental sciences for administrative purposes as provided in 2-15-121.

(3) The authority consists of five voting members appointed by the governor. At least one member must represent consumer organizations. Members of the authority must be appointed as follows:

(a) Within 30 days of [the effective date of this section], the majority and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(b) Within 30 days of [the effective date of this section], the majority and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The majority and minority leader and the person selected by them shall nominate by majority vote five individuals for appointment to the authority.

(c) Within 90 days of [the effective date of this section], the governor shall appoint from those nominated under subsections (3)(a) and (3)(b) five individuals to the authority.

(4) A vacancy must be filled in the same manner as

original appointments under subsection (3), except that one individual must be selected under subsection (3)(a) and one under subsection (3)(b). The governor shall appoint from those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and rehabilitation services and the department of health and environmental sciences and the commissioner of insurance are nonvoting, ex officio members of the authority.

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

NEW SECTION. Section 4. Administration of health care authority -- reports -- compensation. (1) The authority shall employ a full-time executive director who shall conduct or direct the daily operation of the authority. The executive director is exempt from the application of 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 2-18-1013 and serves at the pleasure of the authority. The

executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the authority.

(2) The authority may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. However, the authority may not delegate its rulemaking powers under [sections 1 through 20].

(3) The authority may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The authority may:

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

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

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

(5) The authority shall report to the legislature and

the governor at least twice a year on its progress since the last report in fulfilling the requirements of [sections 1 through 20]. Reports may be provided in a manner similar to 5-11-210 or in another manner determined by the authority.

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

(7) The authority shall make grants to the boards for the operation of the boards. The authority shall provide for uniform procedures for grant applications and budgets of the boards.

NEW SECTION. Section 5. Statewide universal access plans required. (1) On or before October 1, 1994, the authority shall submit a report to the legislature that contains the authority's recommendation for a statewide universal health care access plan based on a single payor system and a recommendation for a statewide universal access plan based on a regulated multiple payor system. Each statewide plan must contain recommendations that, if implemented, would provide for universally accessible, medically necessary, and preventive health care by October 1, 1995. Both plans must be voted on by the 1995 legislature no later than 45 days from the first day of the 1995 legislative session. The legislature may return one or both plans to the authority for further development.

(2) For purposes of this section:

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

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

NEW SECTION. Section 6. Features of statewide plans.

(1) Each statewide plan under [section 5] must contain the features required by [sections 7 through 9 and 11] and this section.

(2) Each statewide plan must include:

- (a) guaranteed access to health care services for all residents of Montana;
- (b) a uniform system of health care benefits;
- (c) a unified health care budget;

- (d) portability of coverage, regardless of job status;
- (e) a broad-based, public or private financing mechanism to fund health care services;
- (f) a system capped for provider expenditures;
- (g) global budgeting for all health care spending;
- (h) controlled capital expenditures;
- (i) a binding cap on overall expenditures;
- (j) policymaking for the system as a whole and accountability within state government;
- (k) incentives to be used to contain costs and direct resources;
- (l) administrative efficiencies;
- (m) the appropriate use of midlevel practitioners, such as physician's assistants and nurse practitioners;
- (n) mechanisms for reducing the cost of prescription drugs, both as part of and as separate from the uniform benefit plan;
- (o) integration, to the extent possible under federal and state law, of benefits provided under the health care system with benefits provided by the Indian health service and the United States department of veteran affairs and benefits provided by the medicare and medicaid programs; and
- (p) an actuarially sound estimate of the costs of implementing the plan through the year 2005.

NEW SECTION. Section 7. Cost containment. (1) The

1 statewide plans must contain a cost containment component.
 2 Except as otherwise provided in this section, each statewide
 3 plan must establish a target for cost containment so that by
 4 1999, the annual average percentage increase in statewide
 5 health care costs does not exceed the average annual
 6 percentage increase in the gross domestic product, as
 7 determined by the U.S. department of commerce, for the 5
 8 preceding years.

9 (2) The authority shall adopt processes and criteria
 10 for responding to exceptional and unforeseen circumstances
 11 that affect the health care system and the target required
 12 in subsection (1), including such factors as population
 13 increases or decreases, demographic changes, costs beyond
 14 the control of health care providers, and other factors that
 15 the authority considers significant.

16 (3) The authority shall include the following features
 17 in the cost containment component:

18 (a) global budgeting for all health care spending;

19 (b) a system for limiting demand of health care
 20 services and controlling unnecessary and inappropriate
 21 health care. The system may include prioritization of
 22 services that allows for consideration of an individual
 23 patient's prognosis.

24 (c) a system for reimbursing health care providers for
 25 services and health care items. The reimbursement system

1 must provide that all payors, public or private, pay the
 2 same rate for the same health care services and items and
 3 that reimbursement for services is based predominantly upon
 4 the health care service provided rather than upon the
 5 discipline of the health care provider.

6 (d) a method of monitoring compliance with the target
 7 required in subsection (1);

8 (e) expenditure targets for health care providers and
 9 facilities;

10 (f) disincentives for exceeding the targets established
 11 pursuant to subsection (3)(e), including reduction of
 12 reimbursement levels in subsequent years;

13 (g) reimbursement of health care providers and health
 14 care facilities that is based upon negotiated annual budgets
 15 or fees for services; and

16 (h) a plan by the authority, health care providers,
 17 health insurers, and health care facilities to educate the
 18 public concerning the purpose and content of the statewide
 19 plans.

20 **NEW SECTION. Section 8. Health care resource**
 21 **management plan.** (1) Each statewide plan must contain a
 22 health care resource management plan that takes into account
 23 the provisions of [section 7]. The management plan must
 24 provide for the distribution of health care resources within
 25 the regions established pursuant to [section 17] and within

1 the state as a whole, consistent with the principles
2 provided in subsection (2).

3 (2) The management plan must include:

4 (a) a statement of principles used in the allocation of
5 resources and in establishing priorities for health
6 services;

7 (b) identification of the current supply and
8 distribution of:

9 (i) hospital, nursing home, and other inpatient
10 services;

11 (ii) home health and mental health services;

12 (iii) treatment services for alcohol and drug abuse;

13 (iv) emergency care;

14 (v) ambulatory care services, including primary care
15 resources;

16 (vi) nutrition benefits, prenatal benefits, and
17 maternity care;

18 (vii) human resources;

19 (viii) major medical equipment; and

20 (ix) health screening and early intervention services;

21 (c) a determination of the appropriate supply and
22 distribution of the resources and services identified in
23 subsection (2)(b) and of the mechanisms that will encourage
24 the appropriate integration of these services on a local or
25 regional basis. To arrive at a determination, the authority

1 shall consider the following factors:

2 (i) the needs of the statewide population, with special
3 consideration given to the development of health care
4 services in underserved areas of the state;

5 (ii) the needs of particular geographic areas of the
6 state;

7 (iii) the use of Montana facilities by out-of-state
8 residents;

9 (iv) the use of out-of-state facilities by Montana
10 residents;

11 (v) the needs of populations with special health care
12 needs;

13 (vi) the desirability of providing high-quality services
14 in an economical and efficient manner, including the
15 appropriate use of midlevel practitioners; and

16 (vii) the cost impact of these resource requirements on
17 health care expenditures;

18 (d) a component that addresses health promotion and
19 disease prevention and that is prepared by the department of
20 health and environmental sciences in a format established by
21 the authority;

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

25 (f) incentives for healthy lifestyles;

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

(i) a system by which the authority may identify persons with an interest in becoming health care professionals and provide or assist in providing health care education for those persons; and

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

(h) a component that addresses integration of the plan, to the extent allowed by state and federal law, with services provided by the Indian health service and by the United States department of veterans affairs and by the medicare and medicaid programs.

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

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

(5) Prior to adoption of the management plan, the authority shall hold one or more public hearings for the purpose of receiving oral and written comment on a draft plan. After hearings have been concluded, the authority shall adopt the management plan, taking comments into consideration.

NEW SECTION. Section 9. Health care billing simplification. (1) Each statewide plan must contain a component providing for simplification and reduction of the costs associated with health care billing. In designing this component, the authority may consider:

(a) conversion from paper health care claims to standardized electronic billing; and

(b) creating a claims clearinghouse, consisting of a state agency or private entity, to receive claims from all health care providers for compiling, editing, and submitting the claims to payors.

(2) The health care billing component must include a method to educate and assist health care providers and payors who will use any health care billing simplification system recommended by the authority.

(3) The billing component must provide a schedule for a phasein of any health care billing simplification system recommended by the authority. The schedule must relieve health care providers, payors, and consumers of undue burdens in using the system.

NEW SECTION. Section 10. Uniform claim forms and procedures. (1) By January 1, 1994, the commissioner of insurance, after consultation with the authority, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and

processing of claims, including the submission of claims by means of an electronic claims processing system.

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

NEW SECTION. Section 11. Other matters to be included in statewide plans. (1) The statewide plans recommended by the authority must include:

(a) stable financing methods, including sharing of the costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phasein of the various components of the plans.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

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

(ii) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

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

(b) As part of its study under subsection (2)(a)(ii), the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be included in its report containing the statewide plans.

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

1 power.

2 (4) The authority shall apply for waivers from federal
3 laws necessary to implement recommendations of the authority
4 enacted by the legislature and to implement those
5 recommendations not requiring legislation.

6 NEW SECTION. Section 12. Hearings on statewide plans.
7 The authority shall seek public comment on the development
8 of each statewide plan required under [section 5]. In
9 seeking public comment on the development of the authority's
10 recommendations for each plan, the authority shall provide
11 extensive, multimedia notice to the public and hold at least
12 one public hearing in each of the health care planning
13 regions established by [section 17]. The hearings must take
14 place before the authority's report is submitted to the
15 legislature. The authority shall consult with health care
16 providers in the development of its recommendations for each
17 statewide plan.

18 NEW SECTION. Section 13. State purchasing pool --
19 reports required. (1) On or before December 15, 1994, and
20 December 15, 1996, the authority shall report to the
21 legislature on establishment of a state purchasing pool,
22 including the number and types of groups and group members
23 participating in the pool, the costs of administering the
24 pool, the savings attributable to participating groups from
25 the operation of the pool, and any changes in legislation

1 considered necessary by the authority.

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

8 NEW SECTION. Section 14. Study of prescription drug
9 cost and distribution. The authority shall conduct a study
10 of the cost and distribution of prescription drugs in this
11 state. The study must consider the feasibility of various
12 methods of reducing the cost of purchasing and distributing
13 prescription drugs to Montana residents. The study must
14 include the feasibility of establishing a prescription drug
15 purchasing pool for distribution of drugs through
16 pharmacists in this state. The results of the study,
17 including the authority's recommendations for any necessary
18 legislation, must be reported to the legislature by December
19 1, 1996. If the authority determines that feasible methods
20 are available without need for legislation or
21 appropriations, the authority shall implement that part or
22 those parts of its recommendations.

23 NEW SECTION. Section 15. Long-term care study and
24 recommendations. (1) The authority shall conduct a study of
25 the long-term care needs of state residents and report to

the public and the legislature the authority's recommendations, including any necessary legislation, for meeting those long-term care needs. The report must be available to the public on or before September 1, 1996, after which the authority shall conduct public hearings on its report in each region established under [section 17]. The authority shall present its report to the legislature on or before January 1, 1997.

(2) This section does not preclude the authority from recommending cost-sharing arrangements for long-term care services or from recommending that the services be phased in over time. The authority's recommendations must support and may not supplant informal care giving by family and friends and must include cost containment recommendations for any long-term care service suggested for inclusion.

(3) The authority's report must estimate costs associated with each of the long-term care services recommended and may suggest independent financing mechanisms for those services. The report must also set forth the projected cost to Montana and its citizens over the next 20 years if there is no change in the present accessibility, affordability, or financing of long-term care services in this state.

(4) The authority shall consult with the department of social and rehabilitation services in developing its

recommendations under this section.

NEW SECTION. Section 16. Study of certificate of need process. (1) The authority shall conduct a study of the certificate of need process established under Title 50, chapter 5, part 3. The study must determine whether changes in the certificate of need process are necessary or desirable in light of the authority's recommendation for a single payor health care system required by [section 5]. The study must include consideration of the role, effect, and desirability of:

(a) maintaining the exemptions from the certificate of need process for offices of private physicians, dentists, and other physical and mental health care professionals; and

(b) maintaining the dollar thresholds for health care services, equipment, and buildings and for construction of health care facilities.

(2) The results of the study, including any recommendations for legislation and changes in an agency's policies or rules, must be reported to the legislature no later than December 1, 1994.

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

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

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

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

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

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

15 (2) (a) A county may, by written request of the board
16 of county commissioners, petition the authority at any time
17 to be removed from a health care planning region and added
18 to another region.

19 (b) The authority shall grant or deny the petition
20 after a public hearing. The authority shall give notice as
21 the authority determines appropriate. The authority shall
22 grant the petition if it appears by a preponderance of the
23 evidence that the petitioning county's health care interests
24 are more strongly associated with the region that the county
25 seeks to join than with the region in which the county is

1 located. If the authority grants the petition, the county is
2 considered for all purposes to be part of the health care
3 planning region as approved by the authority.

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

12 (4) The authority shall, within 30 days of appointment
13 of its members, propose by rule a procedure for selecting
14 members of boards. The authority shall select the members
15 for each board within 180 days of appointment of the
16 authority, using the selection procedure adopted by rule
17 under this subsection. Vacancies on a board must be filled
18 by using the authority's selection process.

19 (5) Regional board members serve 4-year terms, except
20 that of the board members initially selected, at least three
21 members serve for 2 years, at least three members serve for
22 3 years, and at least three members serve for 4 years, to be
23 determined by lot. A majority of each regional board shall
24 select a presiding officer. The presiding officer initially
25 selected must serve a 4-year term. Board members must be

1 compensated and reimbursed in accordance with 2-15-124.

2 **NEW SECTION. Section 18. Powers and duties of boards.**

3 (1) A board shall:

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

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

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

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

17 (e) revise the regional plan annually;

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

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

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

1 authority; and

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

4 (2) Regional boards may:

5 (a) recommend that the authority sanction voluntary
6 agreements between health care providers and between health
7 care consumers in the region that will improve the quality
8 of, access to, or affordability of health care but that
9 might constitute a violation of antitrust laws if undertaken
10 without government direction;

11 (b) make recommendations to the authority regarding
12 major capital expenditures or the introduction of expensive
13 new technologies and medical practices that are being
14 proposed or considered by health care providers;

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

19 (d) make recommendations to the department of health
20 and environmental sciences or to the authority, or both,
21 regarding ways of improving affordability, accessibility,
22 and quality of health care in the region and throughout the
23 state.

24 (3) Each regional board may review and advise the
25 authority on regional technical matters relating to the

1 statewide plans required by [section 5], the common benefits
 2 package, procedures for developing and applying practice
 3 guidelines for use in the statewide plans, provider and
 4 facility contracts with the state, utilization review
 5 recommendations, expenditure targets, and uniform health
 6 care benefits and the impact of the benefits upon the
 7 provision of quality health care within the region.

8 **NEW SECTION. Section 19. Health care data base --**
 9 **information submitted -- enforcement.** (1) The authority
 10 shall develop and maintain a unified health care data base
 11 that enables the authority, on a statewide basis, to:

12 (a) determine the distribution and capacity of health
 13 care resources, including health care facilities, providers,
 14 and health care services;

15 (b) identify health care needs and direct statewide and
 16 regional health care policy to ensure high-quality and
 17 cost-effective health care;

18 (c) conduct evaluations of health care procedures and
 19 health care protocols;

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

24 (e) compare costs of various health care procedures in
 25 one location of providers and health care facilities with

1 the costs of the same procedures in other locations of
 2 providers and health care facilities.

3 (2) The authority shall by rule require health care
 4 providers, health insurers, health care facilities, private
 5 entities, and entities of state and local governments to
 6 file with the authority the reports, data, schedules,
 7 statistics, and other information determined by the
 8 authority to be necessary to fulfill the purposes of the
 9 data base provided in subsection (1). Material to be filed
 10 with the authority may include health insurance claims and
 11 enrollment information used by health insurers.

12 (3) The authority may issue subpoenas for the
 13 production of information required under this section and
 14 may issue subpoenas for and administer oaths to any person.
 15 Noncompliance with a subpoena issued by the authority is,
 16 upon application by the authority, punishable by a district
 17 court as contempt pursuant to Title 3, chapter 1, part 5.

18 (4) The data base must:

19 (a) use unique patient and provider identifiers and a
 20 uniform coding system identifying health care services; and

21 (b) reflect all health care utilization, costs, and
 22 resources in the state and the health care utilization and
 23 costs of services provided to Montana residents in another
 24 state.

25 (5) Information in the data base required by law to be

kept confidential must be maintained in a manner that does not disclose the identity of the person to whom the information applies.

(6) The authority shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

NEW SECTION. Section 20. Health insurer cost management plans. (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the authority no later than January 1, 1994.

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

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

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

Section 21. Section 50-1-201, MCA, is amended to read:

"50-1-201. Administration of state health plan. The department Montana health care authority created in [section 3] is hereby--established--as the sole-and-official state

agency to administer the state program for comprehensive health planning and ~~is hereby authorized to~~ shall prepare a plan for comprehensive state health planning. The department ~~authority is authorized to~~ may confer and cooperate with any ~~and--all~~ other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The department authority, while acting in this capacity as the ~~sole-and-official~~ state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the ~~sole-and-official~~ state agency to accept, receive, expend, and administer ~~any-and-all~~ funds ~~which are now available or which may be~~ donated, granted, bequeathed, or appropriated to it for the preparation, and administration, and the supervision of the preparation and administration of the comprehensive state health plan."

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

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

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

- 1 (b) to prevent abusive rating practices;
 2 (c) to require disclosure of rating practices to
 3 purchasers;
 4 (d) to establish rules regarding renewability of
 5 coverage;
 6 (e) to establish limitations on the use of preexisting
 7 condition exclusions;
 8 (f) to provide for the development of basic and
 9 standard health benefit plans to be offered to all small
 10 employers;
 11 (g) to provide for the establishment of a reinsurance
 12 program; and
 13 (h) to improve the overall fairness and efficiency of
 14 the small employer health insurance market.
 15 (2) [Sections 22 through 36] are not intended to
 16 provide a comprehensive solution to the problem of
 17 affordability of health care or health insurance.

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

- 20 (1) "Actuarial certification" means a written statement
 21 by a member of the American academy of actuaries or other
 22 individual acceptable to the commissioner that a small
 23 employer carrier is in compliance with the provisions of
 24 [section 27], based upon the person's examination, including
 25 a review of the appropriate records and of the actuarial

1 assumptions and methods used by the small employer carrier
 2 in establishing premium rates for applicable health benefit
 3 plans.

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

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

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

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

18 (6) "Carrier" means any person who provides a health
 19 benefit plan in this state subject to state insurance
 20 regulation. The term includes but is not limited to an
 21 insurance company, a fraternal benefit society, a health
 22 service corporation, a health maintenance organization, and,
 23 to the extent permitted by the Employee Retirement Income
 24 Security Act of 1974, a multiple-employer welfare
 25 arrangement. For purposes of [sections 22 through 36],

companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

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

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

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

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

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

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

(10) "Dependent" means:

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

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

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

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

(11) "Eligible employee" means an employee who works on a full-time basis and who has a normal workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

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

(13) "Health benefit plan" means any hospital or medical policy or certificate issued by an insurance company, a

1 fraternal benefit society, or a health service corporation
2 or issued under a health maintenance organization subscriber
3 contract. Health benefit plan does not include:

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

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

10 (c) automobile medical payment insurance.

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

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

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

25 (i) the individual was covered under qualifying

1 previous coverage at the time of the initial enrollment;

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

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

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

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

16 (16) "New business premium rate" means, for each class
17 of business for a rating period, the lowest premium rate
18 charged or offered or that could have been charged or
19 offered by the small employer carrier to small employers
20 with similar case characteristics for newly issued health
21 benefit plans with the same or similar coverage.

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

24 (18) "Premium" means all money paid by a small employer
25 and eligible employees as a condition of receiving coverage

from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

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

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

(a) medicare or medicaid;

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

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

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

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

(23) "Restricted network provision" means a provision of

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

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

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

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

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

1 the following conditions are met:

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

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

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

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

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

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

22 (c) The small employer carrier provides coverage to one
23 or more association groups that meet the requirements of
24 33-22-501(2).

25 (2) A small employer carrier may establish up to nine

1 separate classes of business under subsection (1).

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

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

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

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

19 (b) For each class of business:

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

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

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

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

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small

employer, as determined from the small employer carrier's rate manual for the class of business; and

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

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

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

(f) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage.

(g) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until January 1, 1997. In that

case, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

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

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

(h) A small employer carrier shall:

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

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

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

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

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

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

1 insurance was issued.

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

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

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

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

25 (c) the provisions relating to renewability of policies

1 and contracts; and

2 (d) the provisions relating to any preexisting
3 condition.

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

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

20 (c) A small employer carrier shall make the information
21 and documentation described in subsection (5)(a) available
22 to the commissioner upon request. Except in cases of
23 violations of the provisions of [sections 22 through 36] and
24 except as agreed to by the small employer carrier or as
25 ordered by a court of competent jurisdiction, the

information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

NEW SECTION. Section 28. Renewability of coverage. (1)

A health benefit plan subject to the provisions of [sections 22 through 36] is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

- (a) nonpayment of the required premium;
- (b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;
- (c) noncompliance with the carrier's minimum participation requirements;
- (d) noncompliance with the carrier's employer contribution requirements;
- (e) repeated misuse of a restricted network provision;
- (f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:
 - (i) provide advance notice of this decision under this subsection (1)(f) to the commissioner in each state in which it is licensed; and
 - (ii) at least 180 days prior to the nonrenewal of any

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

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

- (i) not be in the best interests of the policyholders or certificate holders; or
- (ii) impair the carrier's ability to meet its contractual obligations.

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

(3) A small employer carrier that elects not to renew a health benefit plan under subsection (1)(f) is prohibited from writing new business in the small employer market in this state for a period of 5 years from the date of notice to the commissioner.

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

NEW SECTION. Section 29. Availability of coverage --

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

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

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

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

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

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

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

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

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

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

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small

1 employer carrier of a basic or standard health benefit plan
2 on the grounds that the plan does not meet the requirements
3 of [sections 22 through 36].

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

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

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

24 (c) A health benefit plan may exclude coverage for late
25 enrollees for 18 months or for an 18-month preexisting

1 condition exclusion, provided that if both a period of
2 exclusion from coverage and a preexisting condition
3 exclusion are applicable to a late enrollee, the combined
4 period may not exceed 18 months from the date the individual
5 enrolls for coverage under the health benefit plan.

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

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

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

25 (ii) A small employer carrier may not modify a basic or

1 standard health benefit plan with respect to a small
2 employer or any eligible employee or dependent, through
3 riders, endorsements, or otherwise, to restrict or exclude
4 coverage for certain diseases or medical conditions
5 otherwise covered by the health benefit plan.

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

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

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

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

21 (b) A small employer carrier may not be required to
22 provide coverage to small employers pursuant to subsection
23 (1) for any period of time for which the commissioner
24 determines that requiring the acceptance of small employers
25 in accordance with the provisions of subsection (1) would

1 place the small employer carrier in a financially impaired
2 condition.

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

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

14 (b) (i) In selecting the members of the board, the
15 commissioner shall include representatives of small
16 employers, small employer carriers, and other qualified
17 individuals, as determined by the commissioner. At least six
18 of the members of the board must be representatives of small
19 employer carriers, one from each of the five small employer
20 carriers with the highest annual premium volume derived from
21 health benefit plans issued to small employers in Montana in
22 the previous calendar year and one from the remaining small
23 employer carriers. One member of the board must be a person
24 licensed, certified, or otherwise authorized by the laws of
25 Montana to provide health care in the ordinary course of

business or in the practice of a profession. One member of the board must be a small employer who is not active in the health care or insurance fields. One member of the board must be a representative of the general public who is employed by a small employer and is not employed in the health care or insurance fields.

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

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

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

(4) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair,

reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

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

(6) The plan of operation must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (b) A small employer carrier may reinsure an entire

1 employer group within 60 days of the commencement of the
2 group's coverage under a health benefit plan.

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

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

20 (ii) The board annually shall adjust the initial level
21 of claims and maximum limit to be retained by the carrier to
22 reflect increases in costs and utilization within the
23 standard market for health benefit plans within the state.
24 The adjustment may not be less than the annual change in the
25 medical component of the consumer price index for all urban

1 consumers of the United States department of labor, bureau
2 of labor statistics, unless the board proposes and the
3 commissioner approves a lower adjustment factor.

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

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

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

18 (9) (a) As part of the plan of operation, the board
19 shall establish a methodology for determining premium rates
20 to be charged by the program for reinsuring small employers
21 and individuals pursuant to this section. The methodology
22 must include a system for classification of small employers
23 that reflects the types of case characteristics commonly
24 used by small employer carriers in the state. The
25 methodology must provide for the development of base

1 reinsurance premium rates that must be multiplied by the
 2 factors set forth in subsection (9)(b) to determine the
 3 premium rates for the program. The base reinsurance premium
 4 rates must be established by the board, subject to the
 5 approval of the commissioner, and must be set at levels that
 6 reasonably approximate gross premiums charged to small
 7 employers by small employer carriers for health benefit
 8 plans with benefits similar to the standard health benefit
 9 plan, adjusted to reflect retention levels required under
 10 [sections 22 through 36].

11 (b) Premiums for the program are as follows:

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

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

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

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

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

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

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

18 (12) The participation in the program as reinsuring
 19 carriers; the establishment of rates, forms, or procedures;
 20 or any other joint collective action required by [sections
 21 22 through 36] may not be the basis of any legal action,
 22 criminal or civil liability, or penalty against the program
 23 or any of its reinsuring carriers, either jointly or
 24 separately.

25 (13) The board, as part of the plan of operation, shall

1 develop standards setting forth the minimum levels of
 2 compensation to be paid to producers for the sale of basic
 3 and standard health benefit plans. In establishing the
 4 standards, the board shall take into consideration the need
 5 to ensure the broad availability of coverages, the
 6 objectives of the program, the time and effort expended in
 7 placing the coverage, the need to provide ongoing service to
 8 small employers, the levels of compensation currently used
 9 in the industry, and the overall costs of coverage to small
 10 employers selecting these plans.

11 (14) The program is exempt from taxation.

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

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

20 (3) (a) The committee shall recommend benefit levels,
 21 cost-sharing levels, exclusions, and limitations for the
 22 basic health benefit plan and the standard health benefit
 23 plan. The committee shall design a basic health benefit plan
 24 and a standard health benefit plan that contain benefit and
 25 cost-sharing levels that are consistent with the basic

1 method of operation and the benefit plans of health
 2 maintenance organizations, including any restrictions
 3 imposed by federal law.

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

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

9 (ii) case management;

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

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

15 (v) other managed care provisions.

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

20 **NEW SECTION. Section 32. Periodic market evaluation --**
 21 **report.** The board, in consultation with members of the
 22 committee, shall study and report at least every 3 years to
 23 the commissioner on the effectiveness of [sections 22
 24 through 36]. The report must analyze the effectiveness of
 25 [sections 22 through 36] in promoting rate stability,

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

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

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

20 NEW SECTION. **Section 35. Standards to ensure fair**
 21 **marketing.** (1) Each small employer carrier shall actively
 22 market health benefit plan coverage, including the basic and
 23 standard health benefit plans, to eligible small employers
 24 in the state. If a small employer carrier denies coverage
 25 other than the basic or standard health benefit plans to a

1 small employer on the basis of claims experience of the
 2 small employer or the health status or claims experience of
 3 its employees or dependents, the small employer carrier
 4 shall offer the small employer the opportunity to purchase a
 5 basic health benefit plan or a standard health benefit plan.

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

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

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

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

24 (3) (a) Except as provided in subsection (3)(b), a
 25 small employer carrier may not, directly or indirectly,

1 enter into any contract, agreement, or arrangement with a
 2 producer that provides for or results in the compensation
 3 paid to a producer for the sale of a health benefit plan to
 4 be varied because of the health status of the employer's
 5 employees or the claims experience, industry, occupation, or
 6 geographic location of the small employer.

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

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

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

25 (6) A small employer carrier or producer may not induce

1 or otherwise encourage a small employer to separate or
 2 otherwise exclude an employee from health coverage or
 3 benefits provided in connection with the employee's
 4 employment.

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

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

12 (9) (a) A violation of this section by a small employer
 13 carrier or a producer is an unfair trade practice under
 14 33-18-102.

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

22 **NEW SECTION. Section 36.** Restoration of terminated
 23 coverage. The commissioner may promulgate rules to require
 24 small employer carriers, as a condition of transacting
 25 business with small employers in this state after [the

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

9 NEW SECTION. **Section 37.** Codification instructions.
10 (1) [Sections 1 through 20] are intended to be codified as
11 an integral part of Title 50, and the provisions of Title 50
12 apply to [sections 1 through 20].

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

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

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

20 (3) [Sections 22 through 36] are effective January 1,
21 1994.

-End-

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE,
 BIANCHI, HARPER, JERGESON, RYAN, LYNCH, HALLIGAN,
 VAN VALKENBURG, MERCER, CRIPPEN, SQUIRES, GRINDE, COBB,
 CHRISTIAENS, BLAYLOCK, L. NELSON, ECK, STRIZICH, TOOLE,
 COCCHIARELLA, MCCARTHY, WILSON, WATERMAN, BECK, KLAMPE,
 DOWELL, RUSSELL, STANFORD, TUSS, DOLEZAL, DOHERTY,
 PAVLOVICH, WEEDING, BRUSKI-MAUS, NATHE, VAUGHN,
 WELDON, KENNEDY, WILSON, BARTLETT,
 SIMPKINS, HOCKETT, YELLOWTAIL, J. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
 HEALTH CARE ACCESS, HEALTH CARE PLANNING, AND COST
 CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
 PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;
 REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;
 REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING
 FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;
 REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON
 LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH
 PLANNING REGIONS AND BOARDS REQUIRING DEVELOPMENT OF UNIFORM
 CLAIM FORMS AND PROCEDURES; REQUIRING THE AUTHORITY TO
 CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM
 CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH
 CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL

HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND
 DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
 UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR HEALTH
 INSURANCE REFORM REQUIRING HEALTH INSURER COST MANAGEMENT
 PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF
 THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL
 SCIENCES RELATING TO VITAL STATISTICS STATE HEALTH PLANNING;
 PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY
 ACT; AMENDING SECTION 50-15-101 50-1-201, MCA; AND PROVIDING
 EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of legislative intent is required for this
 bill because {section 10} requires the Montana health care
 authority to adopt rules establishing a maximum of five
 health care planning regions, to establish regional health
 care planning boards within those regions, and to establish
 a procedure for selection of regional board members. The

THERE ARE NO CHANGES IN THIS BILL
 AND WILL NOT BE REPRINTED. PLEASE
 REFER TO YELLOW COPY FOR COMPLETE TEXT.

HOUSE STANDING COMMITTEE REPORT

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March 30, 1993
Page 1 of 14

Mr. Speaker: We, the committee on Human Services and Aging report that Senate Bill 285 (third reading copy -- blue) be concurred in as amended.

Signed: Wm F Boharski
Bill Boharski, Chair

And, that such amendments read: Carried by: Rep. Jim Rice

1. Title.
Page 2, line 9
Following: "ACT;"
Insert: "ALLOWING HEALTH CARE FACILITIES TO ENTER INTO COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF THE AUTHORITY;"

2. Page 3, line 24
Following: "~~effective~~,"
Insert: "(1)"

3. Page 4, line 2.
Strike: "(1)"
Insert: "(a)"

4. Page 4, line 9.
Strike: "(2)"
Insert: "(b)"

5. Page 4, line 22.
Strike: "(3)"
Insert: "(c)"

6. Page 5, line 2.
Strike: "(4)"
Insert: "(d)"

7. Page 5, line 14.
Strike: "(5)"
Insert: "(e)"
Following: "30,"
Insert: "31,"

Committee Vote:
Yes 15, No 0.

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8. Page 6.

Following: line 5

Insert: "(f) [section 44] requires the authority to adopt rules implementing [sections 37 through 44]. The rules adopted by the authority must specify the form and content of applications for certificates of public advantage; details of the reconsideration, revocation, hearing, and appeal processes; and other matters as the authority determines necessary. The rules that are adopted by the authority must also provide the authority with direct supervision and control over the implementation of cooperative agreements between facilities.

(2) In preparing the plan required by [section 5], the authority shall consider the following matters for the following features of the plan:

(a) a unified health care budget. The authority shall consider the development of a state health care budget based upon the budgets submitted by the regional health care planning boards.

(b) caps for provider expenditures. The authority shall consider a process for adopting mandatory limits on provider expenses, including fees and salaries.

(c) global budgeting for all health care spending. The authority shall consider adopting a budgeting process, with public involvement, by which a unified health care budget is determined.

(d) controlled capital expenditures. The authority shall consider adopting a system similar to the certificate of need system by which capital expenditures are controlled.

(e) binding cap on overall expenditures. The authority shall consider adopting mandatory limits on all types of expenditures of health care providers, including capital expenditures, small equipment purchases, personnel costs, and all other types of operating costs.

(f) market control. The authority shall consider the development of a state health care plan based upon the preferences and needs of the health care consumer. Incentives for market control should include mechanisms that encourage health care providers to respond to preferences and needs of health care consumers."

9. Page 7.

Following: line 8

Insert: "(e) facilitate universal access to health sciences information;"

Renumber: subsequent subsections

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10. Page 7.

Following: line 12

Insert: "(3) It is further the policy of the state of Montana that regardless of whether or what form of a health care access plan is adopted by the legislature, the health care authority, health care providers, and other persons involved in the delivery of health care services need to increase their emphasis on the education of consumers of health care services. Consumers should be educated concerning the health care system, payment for services, ultimate costs of health care services, and the benefit to consumers generally of providing only services to the consumer that are reasonable and necessary."

11. Page 7, line 14.

Following: "20"

Insert: "and 37 through 44"

12. Page 7.

Following: line 18

Insert: "(3) 'Certificate of public advantage' or 'certificate' means a written certificate issued by the authority as evidence of the authority's intention that the implementation of a cooperative agreement, when actively supervised by the authority, receive state action immunity from prosecution as a violation of state or federal antitrust laws.

(4) 'Cooperative agreement' or 'agreement' means a written agreement between two or more health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care facilities."

Renumber: subsequent subsections

13. Page 7.

Following: line 20

Insert: "(6) 'Health care' includes both physical health care and mental health care."

Renumber: subsequent subsections

14. Page 9, lines 8 and 10.

Strike: "majority"

Insert: "speaker"

15. Page 9, lines 15 and 17.

Strike: "majority"

Insert: "president"

16. Page 10.

Following: line 15

Insert: "(8) The attorney general is an ex officio, nonvoting member of the authority only for the purpose of the authority's approval or denial of certificates of public advantage, supervision of cooperative agreements, and revocation of certificates of public advantage pursuant to [sections 37 through 44]."

Renumber: subsequent subsection

17. Page 11, line 22.

Strike: "and perform other acts"

18. Page 12, line 17.

Following: "system."

Insert: "Each statewide plan must include incentives for market control."

19. Page 12, lines 22 and 23.

Strike: "no later than 45 days from the first day of the 1995 legislative session"

20. Page 13, lines 2 and 9.

Following: "health"

Insert: "care"

21. Page 14.

Following: line 3

Insert: "(f) consideration of the limitations of public funding;"

Renumber: subsequent subsections

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22. Page 14, line 10.
Following: "costs"
Insert: ", provide market control,"

23. Page 14.
Following: line 17
Insert: "(p) incentives for market control;"

Renumber: subsequent subsections

24. Page 14.
Following: line 24
Insert: "(3) Nothing in [sections 7 through 9 and 11] or this section may be interpreted to prevent Montana residents from seeking health care services not provided in either or both statewide plans."

25. Page 15, line 1.
Following: "component"
Insert: ", including annual cost containment targets"

26. Page 15, line 3.
Strike: "a target"
Insert: "targets"

27. Page 15, line 11.
Strike: "target"
Insert: "targets"

28. Page 15, line 16.
Following: "shall"
Insert: ", at a minimum,"

29. Page 15, line 23.
Following: "prognosis"
Insert: "and an individual's choice of services"

30. Page 16, line 6.
Strike: "target"
Insert: "targets"

March 30, 1993
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31. Page 17.
Following: line 18
Insert: "(viii) health sciences library resources and services;"

Renumber: subsequent subsections

32. Page 20, line 22.
Strike: "By January 1, 1994, the"
Insert: "The"

33. Page 22, line 17.
Strike: "shall"
Insert: "may"
Following: "legislation"
Insert: "in addition to [sections 37 through 44]"

34. Page 23, line 6.
Strike: "Hearings"
Insert: "Availability of plans -- hearings"
Following: "plans."
Insert: "(1) The authority shall make copies of the draft statewide plans widely available at public expense to interested persons and groups. (2)"

35. Page 23.
Following: line 17
Insert: "(3) The authority shall consider oral and written public comments on the statewide plans before recommending them to the legislature."

36. Page 26, line 12.
Following: "process for"
Insert: "hospitals and for"

37. Page 30, line 2.
Strike: "local"
Insert: "public and private"

38. Page 33, line 3.
Following: "."
Insert: "Information in the data base not required by law to be kept confidential must be made available by the authority upon request of any person."

39. Page 36.
Following: line 7

Insert: "(3) 'Assessable carrier' means all individual carriers of disability insurance and all carriers of group disability insurance, the state group benefits plan provided for in Title 2, chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state."

Renumber: subsequent subsections

40. Page 38, line 25.

Following: "certificate"

Insert: "providing for physical and mental health care"

41. Page 42, line 15.

Following: "taxation"

Insert: "or that are members of an association that has been in existence for 1 year prior to [the effective date of sections 22 through 36] and that provides a health benefit plan to employees of its members as a group"

42. Page 44, line 2.

Strike: "may"

Insert: "shall"

43. Page 45, line 13.

Strike: ". In"

Insert: "; in"

44. Page 45, line 21.

Strike: "."

Insert: ";

45. Page 46, lines 12 through 15.

Strike: subsection (e) in its entirety

Renumber: subsequent subsections

46. Page 47, line 6.

Strike: ". In"

Insert: "; in"

47. Page 47, line 14.

Strike: "."

Insert: "; and"

48. Page 48, lines 7 through 9.

Strike: subsection (j) in its entirety

Renumber: subsequent subsection

49. Page 48, line 10.

Strike: "may"

Insert: "shall"

50. Page 59, line 18.

Following: "section]"

Insert: "and on or before March 1 of each year after that date"

Strike: "small employer"

Insert: "assessable"

51. Page 59, line 20.

Strike: "to small employers"

52. Page 61, line 2.

Strike: "reinsuring"

Insert: "assessable"

53. Page 61, lines 2 and 3.

Strike: "and administrative expenses"

54. Page 61, line 3.

Strike: "or estimated to be incurred"

55. Page 61, line 4.

Strike: "and"

Insert: "(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and"

Renumber: subsequent subsection

56. Page 61, line 7.

Strike: "must have"

Insert: "has"

57. Page 61, line 12.

Strike: "must have the specific authority to"

Insert: "may"

58. Page 61, line 21.

Strike: "assessments"

Insert: "premiums"

59. Page 62, line 5.

Strike: "rules,"

Following: "conditions"

Strike: ", "

60. Page 62, line 13.

Strike: "and"

Insert: "(h) to the extent permitted by federal law and in accordance with subsection (11)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and"

Renumber: subsequent subsection

61. Page 64, line 8.

Strike: "business"

Insert: "health benefit plan"

62. Page 66, lines 15 through 17.

Following: "(b)" on line 15

Strike: the remainder of line 15 through "." on line 17

Insert: "To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make interim assessments against assessable

carriers to fund claims incurred by the program. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed \$10."

63. Page 67.

Following: line 11

Insert: "(15) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation."

64. Page 67.

Strike: lines 15 and 16

Insert: "the following members:

- (a) one health care provider;
- (b) one representative of the health insurance industry;
- (c) one employee of a small employer;
- (d) one member of a labor union; and
- (e) one representative of the general public who may not represent the persons or groups listed in subsections (1)(a) through (1)(d)."

65. Page 67, line 17.

Following: "shall"

Insert: ", after holding a public hearing,"

66. Page 68, line 18.

Strike: "for approval"

67. Page 68, line 19.

Following: "committee."

Insert: "The commissioner shall adopt as a rule pursuant to Title 2, chapter 4, part 3, the health benefit plans required by [section 29(1)] to be offered in this state."

68. Page 69, line 12.

Strike: "practitioner does"

Insert: "practitioners and a law that requires the coverage of a health care service or benefit do"

69. Page 69, line 15.

Following: "through 36]"

Insert: "but do apply to a standard health benefit plan delivered or issued for delivery to small employers in this state pursuant to [sections 22 through 36]"

70. Page 73.

Following: line 8

Insert: "NEW SECTION. Section 37. Finding and purpose. The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements among health care facilities. The purpose of [sections 37 through 44] is to provide the state, through the authority, with direct supervision and control over the implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws."

NEW SECTION. Section 38. Cooperative agreements allowed. A health care facility may enter into a cooperative agreement with one or more health care facilities.

NEW SECTION. Section 39. Certificate of public advantage -- standards for certification -- time for action by authority. (1) Parties to a cooperative agreement may apply to the authority for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed

agreement, a description of the scope of the cooperation contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The authority shall hold a public hearing on the application for a certificate before acting upon the application. The authority may not issue a certificate unless the authority finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the authority denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the authority not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The authority shall deny the application for a certificate or issue a certificate within 90 days of receipt of a completed application.

NEW SECTION. Section 40. Reconsideration by authority.

(1) If the authority denies an application and refuses to issue a certificate, a party to the agreement may request that the authority reconsider its decision. The authority shall reconsider its decision if the party applying for reconsideration submits the request to the authority in writing within 30 calendar days of the authority's decision to deny the initial application.

(2) The authority shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The authority shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the authority must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration.

NEW SECTION. Section 41. Revocation of certificate by authority. (1) The authority shall revoke a certificate previously granted by it if the authority determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the authority without giving notice and an opportunity for a hearing before the authority as follows:

(a) Written notice of the proposed revocation must be given

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to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the authority within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the authority shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The authority shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the authority, the agreement for which the certificate was issued is terminated.

NEW SECTION. Section 42. Appeal. A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the authority to deny an application for a certificate or a decision by the authority to revoke a certificate. A revocation of a certificate pursuant to [section 41] does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts.

NEW SECTION. Section 43. Record of agreements to be kept. The authority shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to [section 37 through 44]. A party to a cooperative agreement who terminates the agreement shall notify the authority in writing of the termination within 30 days after the termination.

NEW SECTION. Section 44. Rulemaking. The authority shall adopt rules to implement [sections 37 through 43]. The rules shall include rules:

- (1) specifying the form and content of applications for a certificate;
- (2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by [sections 37 through 43], and appeals; and
- (3) to effect the active supervision by the authority of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for

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Page 14 of 14

which a certificate is in effect."

Renumber: subsequent sections

71. Page 73, lines 10 and 12.

Following: "20"

Insert: "and 37 through 44"

72. Page 73.

Following: line 15

Insert: "NEW SECTION. Section 46. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

Renumber: subsequent section

73. Page 73, line 17.

Strike: ", 37,"

Insert: "and 44 through 46"

74. Page 73, line 20.

Following: "through"

Insert: "28, 35, and"

75. Page 73.

Following: line 21

Insert: "(4) [Sections 30 through 34] are effective July 1, 1993."

-END-

3-30-93
10140

710952SC.Hss

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE,
 BIANCHI, HARPER, JERGSON, RYAN, LYNCH, HALLIGAN,
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A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
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 CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
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 PLANNING REGIONS AND BOARDS REQUIRING DEVELOPMENT OF UNIFORM
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 CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH
 CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL

HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND
 DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
 UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR HEALTH
 INSURANCE REFORM REQUIRING HEALTH INSURER COST MANAGEMENT
 PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF
 THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL
 SCIENCES RELATING TO VITAL STATISTICS STATE HEALTH PLANNING;
 PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY
 ACT; ALLOWING HEALTH CARE FACILITIES TO ENTER INTO
 COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF
 THE AUTHORITY; AMENDING SECTION 50-15-101 50-1-201, MCA; AND
 PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of legislative intent is required for this
 bill because section 10 requires the Montana health care
 authority to adopt rules establishing a maximum of five
 health care planning regions, to establish regional health
 care planning boards within those regions, and to establish
 a procedure for selection of regional board members. The
 legislature intends that the rules establishing the health
 care planning regions be based primarily upon the geographic
 health care referral patterns by which health care providers
 refer patients to specialists or larger health care
 facilities. These rules should also consider communication

and-transportation-patterns-and-natural--barriers--to--these
 patterns--The-rules-establishing-the-boards-must-specify-the
 number--of--members--any--relevant--qualifications--and-the
 operations-and-duties-of-the-boards-and-must-provide--for--a
 funding-mechanism-by-grant-from-the-authority--The-procedure
 for--selection--of-the-board-members-must-provide-for-public
 notice-of-the-selection-process.

A-statement-of-intent-is-also-required-because--{section
 12}--requires--the--authority-to-adopt-rules-relating-to-the
 unified-health-care-data-base--The--authority's--rules--must
 specify-in-comprehensive-detail-what-information-is-required
 to--be--provided--by--health-care-providers-and-the-times-at
 which-the-information-is-to-be-provided--The-rules-must-also
 provide-for-audit-procedures-to-determine--the--accuracy--of
 the--filed--data--The--confidentiality--provisions--must-be
 consistent---with---other---state---laws---governing---the
 confidentiality---of---public---records--including--medical
 records--and-must-apply-to-employees-of-the-authority-and-to
 others-receiving-or-using-records-in-the-data-base.

A-statement-of-intent-is-also-required-because--{section
 13}--requires--the--commissioner-of-insurance-to-adopt-rules
 governing-small-employer-group-health-plans--in--determining
 the--basic--benefits--package--the--commissioner-shall-make
 objective--determinations--supported--by--available---data--
 concerning-the-type-of-benefits-required-and-shall-determine

that--the--benefits-to-be-required-are-cost-effective- (1) A
 STATEMENT OF LEGISLATIVE INTENT IS REQUIRED FOR THIS BILL
 BECAUSE:

{1}(A) [SECTION 4] AUTHORIZES THE MONTANA HEALTH CARE
 AUTHORITY TO ADOPT RULES NECESSARY TO IMPLEMENT [SECTIONS 1
 THROUGH 20]. IN ADDITION TO THOSE RULEMAKING MATTERS
 ADDRESSED BELOW, THE AUTHORITY MAY ADOPT RULES GOVERNING
 SUCH MATTERS AS ITS MEETINGS, PUBLIC HEARINGS, AND RULES OF
 PROCEDURE AND RULES OF ETHICAL CONDUCT GOVERNING ITS
 MEMBERS.

{2}(B) [SECTION 17] REQUIRES THE MONTANA HEALTH CARE
 AUTHORITY TO ADOPT RULES TO ESTABLISH REGIONAL HEALTH CARE
 PLANNING BOARDS WITHIN THE HEALTH CARE PLANNING REGIONS
 ESTABLISHED IN [SECTION 17] AND TO ESTABLISH A PROCEDURE FOR
 SELECTION OF REGIONAL BOARD MEMBERS. THE RULES ESTABLISHING
 THE BOARDS MUST SPECIFY THE NUMBER OF MEMBERS, ANY RELEVANT
 QUALIFICATIONS, AND THE OPERATIONS AND DUTIES OF THE BOARDS
 AND MUST PROVIDE FOR A FUNDING MECHANISM BY GRANT FROM THE
 AUTHORITY. IN ADDITION, THE RULES MUST PROVIDE FOR
 CONSIDERATION OF A BALANCE BETWEEN RURAL AND URBAN INTERESTS
 IN THE SELECTION OF REGIONAL BOARD MEMBERS. THE PROCEDURE
 FOR SELECTION OF THE BOARD MEMBERS MUST PROVIDE FOR PUBLIC
 NOTICE OF THE SELECTION PROCESS.

{3}(C) [SECTION 10] GRANTS THE COMMISSIONER OF
 INSURANCE THE AUTHORITY TO ADOPT RULES SPECIFYING UNIFORM

1 HEALTH INSURANCE CLAIM FORMS AND PROCEDURES. THE FORMS
 2 SHOULD BE BASED UPON EXISTING FORMATS, BE AS SHORT AS
 3 POSSIBLE, AND BE COMPATIBLE WITH ELECTRONIC DATA
 4 TRANSMISSION.

5 {4}(D) [SECTION 19] REQUIRES THE AUTHORITY TO ADOPT
 6 RULES RELATING TO THE UNIFIED HEALTH CARE DATA BASE. THE
 7 AUTHORITY'S RULES MUST SPECIFY IN COMPREHENSIVE DETAIL WHAT
 8 INFORMATION IS REQUIRED TO BE PROVIDED BY HEALTH CARE
 9 PROVIDERS AND THE TIMES AT WHICH THE INFORMATION IS TO BE
 10 PROVIDED. THE RULES MUST ALSO PROVIDE FOR AUDIT PROCEDURES
 11 TO DETERMINE THE ACCURACY OF THE FILED DATA. THE
 12 CONFIDENTIALITY PROVISIONS MUST BE CONSISTENT WITH OTHER
 13 STATE LAWS GOVERNING THE CONFIDENTIALITY OF PUBLIC RECORDS,
 14 INCLUDING MEDICAL RECORDS, AND MUST APPLY TO EMPLOYEES OF
 15 THE AUTHORITY AND TO OTHERS RECEIVING OR USING RECORDS IN
 16 THE DATA BASE.

17 {5}(E) [SECTIONS 23, 26, 27, 30, 31, AND 34 THROUGH 36]
 18 REQUIRE THE COMMISSIONER OF INSURANCE TO ADOPT RULES
 19 GOVERNING SMALL EMPLOYER GROUP HEALTH PLANS. IN DETERMINING
 20 THE BASIC BENEFITS PACKAGE, THE COMMISSIONER SHALL MAKE
 21 OBJECTIVE DETERMINATIONS, SUPPORTED BY AVAILABLE DATA,
 22 CONCERNING THE TYPE OF BENEFITS REQUIRED AND SHALL DETERMINE
 23 THAT THE BENEFITS TO BE REQUIRED ARE COST-EFFECTIVE PURSUANT
 24 TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE
 25 COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION

1 PERIOD TO ALLOW SMALL EMPLOYER CARRIERS TO COMPLY WITH
 2 CERTAIN PROVISIONS OF THE ACT. THE COMMISSIONER MAY APPROVE
 3 THE ESTABLISHMENT OF ADDITIONAL CLASSES OF BUSINESSES ONLY
 4 IF THE COMMISSIONER DETERMINES THAT THE ADDITIONAL CLASSES
 5 WOULD ENHANCE THE EFFICIENCY AND FAIRNESS OF THE SMALL
 6 EMPLOYER HEALTH INSURANCE MARKET. THE COMMISSIONER IS
 7 REQUIRED UNDER THE ACT TO ADOPT RULES TO IMPLEMENT AND
 8 ADMINISTER THE ACT.

9 (F) [SECTION 44] REQUIRES THE AUTHORITY TO ADOPT RULES
 10 IMPLEMENTING [SECTIONS 37 THROUGH 44]. THE RULES ADOPTED BY
 11 THE AUTHORITY MUST SPECIFY THE FORM AND CONTENT OF
 12 APPLICATIONS FOR CERTIFICATES OF PUBLIC ADVANTAGE; DETAILS
 13 OF THE RECONSIDERATION, REVOCATION, HEARING, AND APPEAL
 14 PROCESSES; AND OTHER MATTERS AS THE AUTHORITY DETERMINES
 15 NECESSARY. THE RULES THAT ARE ADOPTED BY THE AUTHORITY MUST
 16 ALSO PROVIDE THE AUTHORITY WITH DIRECT SUPERVISION AND
 17 CONTROL OVER THE IMPLEMENTATION OF COOPERATIVE AGREEMENTS
 18 BETWEEN FACILITIES.

19 (2) IN PREPARING THE PLAN REQUIRED BY [SECTION 5], THE
 20 AUTHORITY SHALL CONSIDER THE FOLLOWING MATTERS FOR THE
 21 FOLLOWING FEATURES OF THE PLAN:

22 (A) A UNIFIED HEALTH CARE BUDGET. THE AUTHORITY SHALL
 23 CONSIDER THE DEVELOPMENT OF A STATE HEALTH CARE BUDGET BASED
 24 UPON THE BUDGETS SUBMITTED BY THE REGIONAL HEALTH CARE
 25 PLANNING BOARDS.

(B) CAPS FOR PROVIDER EXPENDITURES. THE AUTHORITY SHALL CONSIDER A PROCESS FOR ADOPTING MANDATORY LIMITS ON PROVIDER EXPENSES, INCLUDING FEES AND SALARIES.

(C) GLOBAL BUDGETING FOR ALL HEALTH CARE SPENDING. THE AUTHORITY SHALL CONSIDER ADOPTING A BUDGETING PROCESS, WITH PUBLIC INVOLVEMENT, BY WHICH A UNIFIED HEALTH CARE BUDGET IS DETERMINED.

(D) CONTROLLED CAPITAL EXPENDITURES. THE AUTHORITY SHALL CONSIDER ADOPTING A SYSTEM SIMILAR TO THE CERTIFICATE OF NEED SYSTEM BY WHICH CAPITAL EXPENDITURES ARE CONTROLLED.

(E) BINDING CAP ON OVERALL EXPENDITURES. THE AUTHORITY SHALL CONSIDER ADOPTING MANDATORY LIMITS ON ALL TYPES OF EXPENDITURES OF HEALTH CARE PROVIDERS, INCLUDING CAPITAL EXPENDITURES, SMALL EQUIPMENT PURCHASES, PERSONNEL COSTS, AND ALL OTHER TYPES OF OPERATING COSTS.

(F) MARKET CONTROL. THE AUTHORITY SHALL CONSIDER THE DEVELOPMENT OF A STATE HEALTH CARE PLAN BASED UPON THE PREFERENCES AND NEEDS OF THE HEALTH CARE CONSUMER. INCENTIVES FOR MARKET CONTROL SHOULD INCLUDE MECHANISMS THAT ENCOURAGE HEALTH CARE PROVIDERS TO RESPOND TO PREFERENCES AND NEEDS OF HEALTH CARE CONSUMERS.

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

(Refer to Introduced Bill)

Strike everything after the enacting clause and insert:

NEW SECTION. Section 1. State health care policy. (1)

It is the policy of the state of Montana to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary to develop a health care system that is integrated and subject to the direction and oversight of a single state agency. Comprehensive health planning through the application of a statewide health care resource management plan that is linked to a unified health care budget for Montana is essential.

(2) It is further the policy of the state of Montana that the health care system should:

(a) maintain and improve the quality of health care services offered to Montanans;

(b) contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income or the money available for other services required to ensure the health, safety, and welfare of Montanans;

(c) avoid unnecessary duplication in the development and offering of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(E) FACILITATE UNIVERSAL ACCESS TO HEALTH SCIENCES

1 INFORMATION;

2 (E)(F) PROMOTE RATIONAL ALLOCATION OF HEALTH CARE
3 RESOURCES IN THE STATE; AND

4 (F)(G) FACILITATE UNIVERSAL ACCESS TO PREVENTIVE AND
5 MEDICALLY NECESSARY HEALTH CARE.

6 (3) IT IS FURTHER THE POLICY OF THE STATE OF MONTANA
7 THAT REGARDLESS OF WHETHER OR WHAT FORM OF A HEALTH CARE
8 ACCESS PLAN IS ADOPTED BY THE LEGISLATURE, THE HEALTH CARE
9 AUTHORITY, HEALTH CARE PROVIDERS, AND OTHER PERSONS INVOLVED
10 IN THE DELIVERY OF HEALTH CARE SERVICES NEED TO INCREASE
11 THEIR EMPHASIS ON THE EDUCATION OF CONSUMERS OF HEALTH CARE
12 SERVICES. CONSUMERS SHOULD BE EDUCATED CONCERNING THE HEALTH
13 CARE SYSTEM, PAYMENT FOR SERVICES, ULTIMATE COSTS OF HEALTH
14 CARE SERVICES, AND THE BENEFIT TO CONSUMERS GENERALLY OF
15 PROVIDING ONLY SERVICES TO THE CONSUMER THAT ARE REASONABLE
16 AND NECESSARY.

17 NEW SECTION. Section 2. Definitions. For the purposes
18 of [sections 1 through 20 AND 37 THROUGH 44], the following
19 definitions apply:

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

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

24 (3) "CERTIFICATE OF PUBLIC ADVANTAGE" OR "CERTIFICATE"
25 MEANS A WRITTEN CERTIFICATE ISSUED BY THE AUTHORITY AS

1 EVIDENCE OF THE AUTHORITY'S INTENTION THAT THE
2 IMPLEMENTATION OF A COOPERATIVE AGREEMENT, WHEN ACTIVELY
3 SUPERVISED BY THE AUTHORITY, RECEIVE STATE ACTION IMMUNITY
4 FROM PROSECUTION AS A VIOLATION OF STATE OR FEDERAL
5 ANTITRUST LAWS.

6 (4) "COOPERATIVE AGREEMENT" OR "AGREEMENT" MEANS A
7 WRITTEN AGREEMENT BETWEEN TWO OR MORE HEALTH CARE FACILITIES
8 FOR THE SHARING, ALLOCATION, OR REFERRAL OF PATIENTS;
9 PERSONNEL; INSTRUCTIONAL PROGRAMS; EMERGENCY MEDICAL
10 SERVICES; SUPPORT SERVICES AND FACILITIES; MEDICAL,
11 DIAGNOSTIC, OR LABORATORY FACILITIES OR PROCEDURES; OR OTHER
12 SERVICES CUSTOMARILY OFFERED BY HEALTH CARE FACILITIES.

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

15 (6) "HEALTH CARE" INCLUDES BOTH PHYSICAL HEALTH CARE
16 AND MENTAL HEALTH CARE.

17 (7) "Health care facility" means all facilities and
18 institutions, whether public or private, proprietary or
19 nonprofit, that offer diagnosis, treatment, and inpatient or
20 ambulatory care to two or more unrelated persons. The term
21 includes all facilities and institutions included in
22 50-5-101(19). The term does not apply to a facility operated
23 by religious groups relying solely on spiritual means,
24 through prayer, for healing.

25 (8) "Health insurer" means any health insurance

1 company, health service corporation, health maintenance
2 organization, insurer providing disability insurance as
3 described in 33-1-207, and, to the extent permitted under
4 federal law, any administrator of an insured, self-insured,
5 or publicly funded health care benefit plan offered by
6 public and private entities.

7 {6}(9) "Health care provider" or "provider" means a
8 person who is licensed, certified, or otherwise authorized
9 by the laws of this state to provide health care in the
10 ordinary course of business or practice of a profession.

11 {7}(10) "Management plan" means the health care resource
12 management plan required by [section 8].

13 {8}(11) "Region" means one of the health care planning
14 regions created pursuant to [section 17].

15 {9}(12) "Statewide plan" means one of the statewide
16 universal health care access plans for access to health care
17 required by [section 5].

18 **NEW SECTION. Section 3. Montana health care authority**
19 **-- allocation -- membership.** (1) There is a Montana health
20 care authority.

21 (2) The authority is allocated to the department of
22 health and environmental sciences for administrative
23 purposes as provided in 2-15-121.

24 (3) The authority consists of five voting members
25 appointed by the governor. At least one member must

1 represent consumer organizations. Members of the authority
2 must be appointed as follows:

3 (a) Within 30 days of [the effective date of this
4 section], the majority SPEAKER and minority leader of the
5 house of representatives shall select an individual with
6 recognized expertise or interest, or both, in health care.
7 The majority SPEAKER and minority leader and the person
8 selected by them shall nominate by majority vote five
9 individuals for appointment to the authority.

10 (b) Within 30 days of [the effective date of this
11 section], the majority PRESIDENT and minority leader of the
12 senate shall select an individual with recognized expertise
13 or interest, or both, in health care. The majority PRESIDENT
14 and minority leader and the person selected by them shall
15 nominate by majority vote five individuals for appointment
16 to the authority.

17 (c) Within 90 days of [the effective date of this
18 section], the governor shall appoint from those nominated
19 under subsections (3)(a) and (3)(b) five individuals to the
20 authority.

21 (4) A vacancy must be filled in the same manner as
22 original appointments under subsection (3), except that one
23 individual must be selected under subsection (3)(a) and one
24 under subsection (3)(b). The governor shall appoint from
25 those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and rehabilitation services and the department of health and environmental sciences and the commissioner of insurance are nonvoting, ex officio members of the authority.

(8) THE ATTORNEY GENERAL IS AN EX OFFICIO, NONVOTING MEMBER OF THE AUTHORITY ONLY FOR THE PURPOSE OF THE AUTHORITY'S APPROVAL OR DENIAL OF CERTIFICATES OF PUBLIC ADVANTAGE, SUPERVISION OF COOPERATIVE AGREEMENTS, AND REVOCATION OF CERTIFICATES OF PUBLIC ADVANTAGE PURSUANT TO [SECTIONS 37 THROUGH 44].

~~(8)~~(9) A member shall acknowledge a direct conflict of interest in a proceeding in which the member has a personal or financial interest.

NEW SECTION. Section 4. Administration of health care authority -- reports -- compensation. (1) The authority shall employ a full-time executive director who shall conduct or direct the daily operation of the authority. The executive director is exempt from the application of

2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 2-18-1013 and serves at the pleasure of the authority. The executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the authority.

(2) The authority may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. However, the authority may not delegate its rulemaking powers under [sections 1 through 20].

(3) The authority may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The authority may:

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

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

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

20].

(5) The authority shall report to the legislature and the governor at least twice a year on its progress since the last report in fulfilling the requirements of [sections 1 through 20]. Reports may be provided in a manner similar to 5-11-210 or in another manner determined by the authority.

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

(7) The authority shall make grants to the boards for the operation of the boards. The authority shall provide for uniform procedures for grant applications and budgets of the boards.

NEW SECTION. Section 5. Statewide universal access plans required. (1) On or before October 1, 1994, the authority shall submit a report to the legislature that contains the authority's recommendation for a statewide universal health care access plan based on a single payor system and a recommendation for a statewide universal access plan based on a regulated multiple payor system. EACH STATEWIDE PLAN MUST INCLUDE INCENTIVES FOR MARKET CONTROL. Each statewide plan must contain recommendations that, if implemented, would provide for universally accessible, medically necessary, and preventive health care by October 1, 1995. Both plans must be voted on by the 1995 legislature no-later-than-45--days--from--the--first--day--of--the--1995

legislative--session. The legislature may return one or both plans to the authority for further development.

(2) For purposes of this section:

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

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

NEW SECTION. Section 6. Features of statewide plans.

(1) Each statewide plan under [section 5] must contain the features required by [sections 7 through 9 and 11] and this section.

(2) Each statewide plan must include:

(a) guaranteed access to health care services for all

1 residents of Montana;

2 (b) a uniform system of health care benefits;

3 (c) a unified health care budget;

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

5 (e) a broad-based, public or private financing

6 mechanism to fund health care services;

7 (F) CONSIDERATION OF THE LIMITATIONS OF PUBLIC FUNDING;

8 ~~(f)~~(G) a system capped for provider expenditures;

9 ~~(g)~~(H) global budgeting for all health care spending;

10 ~~(h)~~(I) controlled capital expenditures;

11 ~~(i)~~(J) a binding cap on overall expenditures;

12 ~~(j)~~(K) policymaking for the system as a whole and

13 accountability within state government;

14 ~~(k)~~(L) incentives to be used to contain costs, PROVIDE

15 MARKET CONTROL, and direct resources;

16 ~~(l)~~(M) administrative efficiencies;

17 ~~(m)~~(N) the appropriate use of midlevel practitioners,

18 such as physician's assistants and nurse practitioners;

19 ~~(n)~~(O) mechanisms for reducing the cost of prescription

20 drugs, both as part of and as separate from the uniform

21 benefit plan;

22 (P) INCENTIVES FOR MARKET CONTROL;

23 ~~(o)~~(Q) integration, to the extent possible under

24 federal and state law, of benefits provided under the health

25 care system with benefits provided by the Indian health

1 service and the United States department of veteran affairs

2 and benefits provided by the medicare and medicaid programs;

3 and

4 ~~(p)~~(R) an actuarially sound estimate of the costs of

5 implementing the plan through the year 2005.

6 (3) NOTHING IN [SECTIONS 7 THROUGH 9 AND 11] OR THIS

7 SECTION MAY BE INTERPRETED TO PREVENT MONTANA RESIDENTS FROM

8 SEEKING HEALTH CARE SERVICES NOT PROVIDED IN EITHER OR BOTH

9 STATEWIDE PLANS.

10 NEW SECTION. Section 7. Cost containment. (1) The

11 statewide plans must contain a cost containment component,

12 INCLUDING ANNUAL COST CONTAINMENT TARGETS. Except as

13 otherwise provided in this section, each statewide plan must

14 establish ~~a-target~~ TARGETS for cost containment so that by

15 1999, the annual average percentage increase in statewide

16 health care costs does not exceed the average annual

17 percentage increase in the gross domestic product, as

18 determined by the U.S. department of commerce, for the 5

19 preceding years.

20 (2) The authority shall adopt processes and criteria

21 for responding to exceptional and unforeseen circumstances

22 that affect the health care system and the target TARGETS

23 required in subsection (1), including such factors as

24 population increases or decreases, demographic changes,

25 costs beyond the control of health care providers, and other

factors that the authority considers significant.

(3) The authority shall, AT A MINIMUM, include the following features in the cost containment component:

(a) global budgeting for all health care spending;

(b) a system for limiting demand of health care services and controlling unnecessary and inappropriate health care. The system may include prioritization of services that allows for consideration of an individual patient's prognosis AND AN INDIVIDUAL'S CHOICE OF SERVICES.

(c) a system for reimbursing health care providers for services and health care items. The reimbursement system must provide that all payors, public or private, pay the same rate for the same health care services and items and that reimbursement for services is based predominantly upon the health care service provided rather than upon the discipline of the health care provider.

(d) a method of monitoring compliance with the target TARGETS required in subsection (1);

(e) expenditure targets for health care providers and facilities;

(f) disincentives for exceeding the targets established pursuant to subsection (3)(e), including reduction of reimbursement levels in subsequent years;

(g) reimbursement of health care providers and health care facilities that is based upon negotiated annual budgets

or fees for services; and

(h) a plan by the authority, health care providers, health insurers, and health care facilities to educate the public concerning the purpose and content of the statewide plans.

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

(2) The management plan must include:

(a) a statement of principles used in the allocation of resources and in establishing priorities for health services;

(b) identification of the current supply and distribution of:

(i) hospital, nursing home, and other inpatient services;

(ii) home health and mental health services;

(iii) treatment services for alcohol and drug abuse;

(iv) emergency care;

(v) ambulatory care services, including primary care

1 resources;

2 (vi) nutrition benefits, prenatal benefits, and

3 maternity care;

4 (vii) human resources;

5 (VIII) HEALTH SCIENCES LIBRARY RESOURCES AND SERVICES;

6 ~~(viii)~~(IX) major medical equipment; and

7 ~~(ix)~~(X) health screening and early intervention

8 services;

9 (c) a determination of the appropriate supply and

10 distribution of the resources and services identified in

11 subsection (2)(b) and of the mechanisms that will encourage

12 the appropriate integration of these services on a local or

13 regional basis. To arrive at a determination, the authority

14 shall consider the following factors:

15 (i) the needs of the statewide population, with special

16 consideration given to the development of health care

17 services in underserved areas of the state;

18 (ii) the needs of particular geographic areas of the

19 state;

20 (iii) the use of Montana facilities by out-of-state

21 residents;

22 (iv) the use of out-of-state facilities by Montana

23 residents;

24 (v) the needs of populations with special health care

25 needs;

1 (vi) the desirability of providing high-quality services

2 in an economical and efficient manner, including the

3 appropriate use of midlevel practitioners; and

4 (vii) the cost impact of these resource requirements on

5 health care expenditures;

6 (d) a component that addresses health promotion and

7 disease prevention and that is prepared by the department of

8 health and environmental sciences in a format established by

9 the authority;

10 (e) incentives to improve access to and use of

11 preventive care; primary care services, including mental

12 health services; and community-based care;

13 (f) incentives for healthy lifestyles;

14 (g) incentives to improve access to health care in

15 underserved areas, including:

16 (i) a system by which the authority may identify

17 persons with an interest in becoming health care

18 professionals and provide or assist in providing health care

19 education for those persons; and

20 (ii) tax credits and other financial incentives to

21 attract and retain health care professionals in underserved

22 areas; and

23 (h) a component that addresses integration of the plan,

24 to the extent allowed by state and federal law, with

25 services provided by the Indian health service and by the

United States department of veterans affairs and by the medicare and medicaid programs.

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

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

(5) Prior to adoption of the management plan, the authority shall hold one or more public hearings for the purpose of receiving oral and written comment on a draft plan. After hearings have been concluded, the authority shall adopt the management plan, taking comments into consideration.

NEW SECTION. Section 9. Health care billing simplification. (1) Each statewide plan must contain a component providing for simplification and reduction of the costs associated with health care billing. In designing this component, the authority may consider:

(a) conversion from paper health care claims to standardized electronic billing; and

(b) creating a claims clearinghouse, consisting of a state agency or private entity, to receive claims from all health care providers for compiling, editing, and submitting the claims to payors.

(2) The health care billing component must include a

method to educate and assist health care providers and payors who will use any health care billing simplification system recommended by the authority.

(3) The billing component must provide a schedule for a phasein of any health care billing simplification system recommended by the authority. The schedule must relieve health care providers, payors, and consumers of undue burdens in using the system.

NEW SECTION. Section 10. Uniform claim forms and procedures. (1) ~~By January 17, 1994, the~~ THE commissioner of insurance, after consultation with the authority, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system.

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

NEW SECTION. Section 11. Other matters to be included in statewide plans. (1) The statewide plans recommended by the authority must include:

(a) stable financing methods, including sharing of the

costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phasein of the various components of the plans.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

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

(ii) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

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

(b) As part of its study under subsection (2)(a)(ii), the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be included in its report containing the statewide plans.

(3) The authority shall conduct a study of the impacts of federal and state antitrust laws on health care services in the state and make recommendations, including legislation, to address those laws and impacts. The authority ~~shall~~ MAY include in its plans legislation IN ADDITION TO [SECTIONS 37 THROUGH 44] that will enable health care providers and payors, including health insurers and consumers, to negotiate and enter into agreements when the agreements are likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. In proposing appropriate legislation concerning antitrust laws, the authority shall provide appropriate conditions, supervision, and regulation to protect against private abuse of economic power.

(4) The authority shall apply for waivers from federal laws necessary to implement recommendations of the authority enacted by the legislature and to implement those recommendations not requiring legislation.

NEW SECTION. Section 12. -Hearings AVAILABILITY OF PLANS -- HEARINGS on statewide plans. (1) THE AUTHORITY SHALL MAKE COPIES OF THE DRAFT STATEWIDE PLANS WIDELY AVAILABLE AT PUBLIC EXPENSE TO INTERESTED PERSONS AND GROUPS.

(2) The authority shall seek public comment on the development of each statewide plan required under [section

5]. In seeking public comment on the development of the authority's recommendations for each plan, the authority shall provide extensive, multimedia notice to the public and hold at least one public hearing in each of the health care planning regions established by [section 17]. The hearings must take place before the authority's report is submitted to the legislature. The authority shall consult with health care providers in the development of its recommendations for each statewide plan.

(3) THE AUTHORITY SHALL CONSIDER ORAL AND WRITTEN PUBLIC COMMENTS ON THE STATEWIDE PLANS BEFORE RECOMMENDING THEM TO THE LEGISLATURE.

NEW SECTION. Section 13. State purchasing pool -- reports required. (1) On or before December 15, 1994, and December 15, 1996, the authority shall report to the legislature on establishment of a state purchasing pool, including the number and types of groups and group members participating in the pool, the costs of administering the pool, the savings attributable to participating groups from the operation of the pool, and any changes in legislation considered necessary by the authority.

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

including a common benefits plan, to participants of the purchasing pool.

NEW SECTION. Section 14. Study of prescription drug cost and distribution. The authority shall conduct a study of the cost and distribution of prescription drugs in this state. The study must consider the feasibility of various methods of reducing the cost of purchasing and distributing prescription drugs to Montana residents. The study must include the feasibility of establishing a prescription drug purchasing pool for distribution of drugs through pharmacists in this state. The results of the study, including the authority's recommendations for any necessary legislation, must be reported to the legislature by December 1, 1996. If the authority determines that feasible methods are available without need for legislation or appropriations, the authority shall implement that part or those parts of its recommendations.

NEW SECTION. Section 15. Long-term care study and recommendations. (1) The authority shall conduct a study of the long-term care needs of state residents and report to the public and the legislature the authority's recommendations, including any necessary legislation, for meeting those long-term care needs. The report must be available to the public on or before September 1, 1996, after which the authority shall conduct public hearings on

its report in each region established under [section 17].
The authority shall present its report to the legislature on
or before January 1, 1997.

(2) This section does not preclude the authority from
recommending cost-sharing arrangements for long-term care
services or from recommending that the services be phased in
over time. The authority's recommendations must support and
may not supplant informal care giving by family and friends
and must include cost containment recommendations for any
long-term care service suggested for inclusion.

(3) The authority's report must estimate costs
associated with each of the long-term care services
recommended and may suggest independent financing mechanisms
for those services. The report must also set forth the
projected cost to Montana and its citizens over the next 20
years if there is no change in the present accessibility,
affordability, or financing of long-term care services in
this state.

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

**NEW SECTION. Section 16. Study of certificate of need
process.** (1) The authority shall conduct a study of the
certificate of need process established under Title 50,
chapter 5, part 3. The study must determine whether changes

in the certificate of need process are necessary or
desirable in light of the authority's recommendation for a
single payor health care system required by [section 5]. The
study must include consideration of the role, effect, and
desirability of:

(a) maintaining the exemptions from the certificate of
need process for HOSPITALS AND FOR offices of private
physicians, dentists, and other physical and mental health
care professionals; and

(b) maintaining the dollar thresholds for health care
services, equipment, and buildings and for construction of
health care facilities.

(2) The results of the study, including any
recommendations for legislation and changes in an agency's
policies or rules, must be reported to the legislature no
later than December 1, 1994.

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

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

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

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

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

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

(2) (a) A county may, by written request of the board of county commissioners, petition the authority at any time to be removed from a health care planning region and added to another region.

(b) The authority shall grant or deny the petition after a public hearing. The authority shall give notice as the authority determines appropriate. The authority shall grant the petition if it appears by a preponderance of the evidence that the petitioning county's health care interests are more strongly associated with the region that the county seeks to join than with the region in which the county is located. If the authority grants the petition, the county is considered for all purposes to be part of the health care planning region as approved by the authority.

(3) Within each region, the authority shall establish

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

(4) The authority shall, within 30 days of appointment of its members, propose by rule a procedure for selecting members of boards. The authority shall select the members for each board within 180 days of appointment of the authority, using the selection procedure adopted by rule under this subsection. Vacancies on a board must be filled by using the authority's selection process.

(5) Regional board members serve 4-year terms, except that of the board members initially selected, at least three members serve for 2 years, at least three members serve for 3 years, and at least three members serve for 4 years, to be determined by lot. A majority of each regional board shall select a presiding officer. The presiding officer initially selected must serve a 4-year term. Board members must be compensated and reimbursed in accordance with 2-15-124.

NEW SECTION. Section 18. Powers and duties of boards.

(1) A board shall:

(a) meet at the time and place designated by the

1 presiding officer, but not less than quarterly;

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

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

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

13 (e) revise the regional plan annually;

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

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

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

23 (i) seek from local PUBLIC AND PRIVATE sources money to
24 supplement grant funds provided by the authority.

25 (2) Regional boards may:

1 (a) recommend that the authority sanction voluntary
2 agreements between health care providers and between health
3 care consumers in the region that will improve the quality
4 of, access to, or affordability of health care but that
5 might constitute a violation of antitrust laws if undertaken
6 without government direction;

7 (b) make recommendations to the authority regarding
8 major capital expenditures or the introduction of expensive
9 new technologies and medical practices that are being
10 proposed or considered by health care providers;

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

15 (d) make recommendations to the department of health
16 and environmental sciences or to the authority, or both,
17 regarding ways of improving affordability, accessibility,
18 and quality of health care in the region and throughout the
19 state.

20 (3) Each regional board may review and advise the
21 authority on regional technical matters relating to the
22 statewide plans required by [section 5], the common benefits
23 package, procedures for developing and applying practice
24 guidelines for use in the statewide plans, provider and
25 facility contracts with the state, utilization review

recommendations, expenditure targets, and uniform health care benefits and the impact of the benefits upon the provision of quality health care within the region.

NEW SECTION. Section 19. Health care data base --
information submitted -- enforcement. (1) The authority shall develop and maintain a unified health care data base that enables the authority, on a statewide basis, to:

(a) determine the distribution and capacity of health care resources, including health care facilities, providers, and health care services;

(b) identify health care needs and direct statewide and regional health care policy to ensure high-quality and cost-effective health care;

(c) conduct evaluations of health care procedures and health care protocols;

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

(e) compare costs of various health care procedures in one location of providers and health care facilities with the costs of the same procedures in other locations of providers and health care facilities.

(2) The authority shall by rule require health care providers, health insurers, health care facilities, private

entities, and entities of state and local governments to file with the authority the reports, data, schedules, statistics, and other information determined by the authority to be necessary to fulfill the purposes of the data base provided in subsection (1). Material to be filed with the authority may include health insurance claims and enrollment information used by health insurers.

(3) The authority may issue subpoenas for the production of information required under this section and may issue subpoenas for and administer oaths to any person. Noncompliance with a subpoena issued by the authority is, upon application by the authority, punishable by a district court as contempt pursuant to Title 3, chapter 1, part 5.

(4) The data base must:

(a) use unique patient and provider identifiers and a uniform coding system identifying health care services; and

(b) reflect all health care utilization, costs, and resources in the state and the health care utilization and costs of services provided to Montana residents in another state.

(5) Information in the data base required by law to be kept confidential must be maintained in a manner that does not disclose the identity of the person to whom the information applies. INFORMATION IN THE DATA BASE NOT REQUIRED BY LAW TO BE KEPT CONFIDENTIAL MUST BE MADE

AVAILABLE BY THE AUTHORITY UPON REQUEST OF ANY PERSON.

(6) The authority shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

NEW SECTION. Section 20. Health insurer cost management plans. (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the authority no later than January 1, 1994.

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

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

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

Section 21. Section 50-1-201, MCA, is amended to read:

"50-1-201. Administration of state health plan. The department Montana health care authority created in [section 3] is hereby--established--as the sole-and-official state agency to administer the state program for comprehensive health planning and ~~is hereby authorized to~~ shall prepare a

plan for comprehensive state health planning. The ~~department authority is authorized to~~ may confer and cooperate with any and--all other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The ~~department~~ authority, while acting in this capacity as the ~~sole-and-official~~ state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the ~~sole-and-official~~ state agency to accept, receive, expend, and administer ~~any-and-all~~ funds ~~which are now available or which may be~~ donated, granted, bequeathed, or appropriated to it for the preparation, and administration, and the supervision of the preparation and administration of the comprehensive state health plan."

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

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

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

(b) to prevent abusive rating practices;

(c) to require disclosure of rating practices to

1 purchasers;

2 (d) to establish rules regarding renewability of
3 coverage;

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

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

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

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

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

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

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

1 plans.

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

6 (3) "ASSESSABLE CARRIER" MEANS ALL INDIVIDUAL CARRIERS
7 OF DISABILITY INSURANCE AND ALL CARRIERS OF GROUP DISABILITY
8 INSURANCE, THE STATE GROUP BENEFITS PLAN PROVIDED FOR IN
9 TITLE 2, CHAPTER 18, PART 8, THE MONTANA UNIVERSITY SYSTEM
10 HEALTH PLAN, AND ANY SELF-FUNDED DISABILITY INSURANCE PLAN
11 PROVIDED BY A POLITICAL SUBDIVISION OF THE STATE.

12 †3†(4) "Base premium rate" means, for each class of
13 business as to a rating period, the lowest premium rate
14 charged or that could have been charged under the rating
15 system for that class of business by the small employer
16 carrier to small employers with similar case characteristics
17 for health benefit plans with the same or similar coverage.

18 †4†(5) "Basic health benefit plan" means a lower cost
19 health benefit plan developed pursuant to [section 31].

20 †5†(6) "Board" means the board of directors of the
21 program established pursuant to [section 30].

22 †6†(7) "Carrier" means any person who provides a health
23 benefit plan in this state subject to state insurance
24 regulation. The term includes but is not limited to an
25 insurance company, a fraternal benefit society, a health

1 service corporation, a health maintenance organization, and,
 2 to the extent permitted by the Employee Retirement Income
 3 Security Act of 1974, a multiple-employer welfare
 4 arrangement. For purposes of [sections 22 through 36],
 5 companies that are affiliated companies or that are eligible
 6 to file a consolidated tax return must be treated as one
 7 carrier, except that the following may be considered as
 8 separate carriers:

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

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

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

18 ~~(7)~~(8) "Case characteristics" means demographic or
 19 other objective characteristics of a small employer that are
 20 considered by the small employer carrier in the
 21 determination of premium rates for the small employer,
 22 provided that claims experience, health status, and duration
 23 of coverage are not case characteristics for purposes of
 24 [sections 22 through 36].

25 ~~(8)~~(9) "Class of business" means all or a separate

1 grouping of small employers established pursuant to [section
 2 26].

3 ~~(9)~~(10) "Committee" means the health benefit plan
 4 committee created pursuant to [section 31].

5 ~~(10)~~(11) "Dependent" means:

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

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

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

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

15 ~~(11)~~(12) "Eligible employee" means an employee who works
 16 on a full-time basis and who has a normal workweek of 30
 17 hours or more. The term includes a sole proprietor, a
 18 partner of a partnership, and an independent contractor if
 19 the sole proprietor, partner, or independent contractor is
 20 included as an employee under a health benefit plan of a
 21 small employer. The term does not include an employee who
 22 works on a part-time, temporary, or substitute basis.

23 ~~(12)~~(13) "Established geographic service area" means a
 24 geographic area, as approved by the commissioner and based
 25 on the carrier's certificate of authority to transact

insurance in this state, within which the carrier is authorized to provide coverage.

{13}(14) "Health benefit plan" means any hospital or medical policy or certificate PROVIDING FOR PHYSICAL AND MENTAL HEALTH CARE issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

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

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

(c) automobile medical payment insurance.

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

{15}(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However,

an eligible employee or dependent may not be considered a late enrollee if:

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

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

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

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

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

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

{16}(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health

benefit plans with the same or similar coverage.

~~(17)~~(18) "Plan of operation" means the operation of the program established pursuant to [section 30].

~~(18)~~(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

~~(19)~~(20) "Program" means the Montana small employer health reinsurance program created by [section 30].

~~(20)~~(21) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

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

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

~~(21)~~(22) "Rating period" means the calendar period for

which premium rates established by a small employer carrier are assumed to be in effect.

~~(22)~~(23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to [section 30].

~~(23)~~(24) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

~~(24)~~(25) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation OR THAT ARE MEMBERS OF AN ASSOCIATION THAT HAS BEEN IN EXISTENCE FOR 1 YEAR PRIOR TO [THE EFFECTIVE DATE OF SECTIONS 22 THROUGH 36] AND THAT PROVIDES A HEALTH BENEFIT PLAN TO EMPLOYEES OF ITS MEMBERS

1 AS A GROUP are considered one employer.

2 ~~†25†~~(26) "Small employer carrier" means a carrier that
3 offers health benefit plans that cover eligible employees of
4 one or more small employers in this state.

5 ~~†26†~~(27) "Standard health benefit plan" means a health
6 benefit plan developed pursuant to [section 31].

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

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

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

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

22 NEW SECTION. Section 26. Establishment of classes of
23 business. (1) A small employer carrier may establish a
24 separate class of business only to reflect substantial
25 differences in expected claims experience or administrative

1 costs that are related to the following reasons:

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

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

7 (c) The small employer carrier provides coverage to one
8 or more association groups that meet the requirements of
9 33-22-501(2).

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

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

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

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

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

(b) For each class of business:

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

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

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

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; ~~in~~ IN the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the

small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; i

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

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

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

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

1 ~~{f}~~(E) If a small employer carrier uses industry as a
 2 case characteristic in establishing premium rates, the rate
 3 factor associated with any industry classification may not
 4 vary from the average of the rate factors associated with
 5 all industry classifications by more than 15% of that
 6 coverage.

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

14 (i) the percentage change in the new business premium
 15 rate measured from the first day of the prior rating period
 16 to the first day of the new rating period; ~~in; IN~~ the case
 17 of a health benefit plan into which the small employer
 18 carrier is no longer enrolling new small employers, the
 19 small employer carrier shall use the percentage change in
 20 the base premium rate, provided that the change does not
 21 exceed, on a percentage basis, the change in the new
 22 business premium rate for the most similar health benefit
 23 plan into which the small employer carrier is actively
 24 enrolling new small employers; AND

25 (ii) any adjustment because of a change in coverage or a

1 change in the case characteristics of the small employer, as
 2 determined from the small employer carrier's rate manual for
 3 the class of business.

4 ~~{h}~~(G) A small employer carrier shall:

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

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

13 ~~{i}~~(H) For the purposes of this subsection (1), a
 14 health benefit plan that includes a restricted network
 15 provision may not be considered similar coverage to a health
 16 benefit plan that does not include a restricted network
 17 provision.

18 ~~{j}~~--The--small--employer--carrier--may--not--use--case
 19 characteristics--other--than--age--without--prior--approval--of
 20 the--commissioner--

21 ~~{k}~~(I) The commissioner may SHALL adopt rules to
 22 implement the provisions of this section and to ensure that
 23 rating practices used by small employer carriers are
 24 consistent with the purposes of [sections 22 through 36],
 25 including rules that ensure that differences in rates

1 charged for health benefit plans by small employer carriers
2 are reasonable and reflect objective differences in plan
3 design, not including differences because of the nature of
4 the groups.

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

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

23 (4) In connection with the offering for sale of any
24 health benefit plan to a small employer, a small employer
25 carrier shall make a reasonable disclosure, as part of its

1 solicitation and sales materials, of each of the following:

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

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

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

13 (d) the provisions relating to any preexisting
14 condition.

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

22 (b) Each small employer carrier shall file with the
23 commissioner annually, on or before March 15, an actuarial
24 certification certifying that the carrier is in compliance
25 with [sections 22 through 36] and that the rating methods of

the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

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

NEW SECTION. Section 28. Renewability of coverage. (1)

A health benefit plan subject to the provisions of [sections 22 through 36] is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

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

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

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

(e) repeated misuse of a restricted network provision;

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

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

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

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

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

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

(2) If the commissioner makes a finding under

subsection (1)(g), the commissioner shall assist affected small employers in finding replacement coverage.

(3) A small employer carrier that elects not to renew a health benefit plan under subsection (1)(f) is prohibited from writing new business in the small employer market in this state for a period of 5 years from the date of notice to the commissioner.

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

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

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

(ii) In the case of a small employer carrier that

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

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

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

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

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

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

(c) The provisions of this section are effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed

1 pursuant to [section 31], provided that if the program
2 created pursuant to [section 30] is not yet operative on
3 that date, the provisions of this section are effective on
4 the date that the program begins operation.

5 (2) (a) A small employer carrier shall, pursuant to
6 33-1-501, file the basic health benefit plans and the
7 standard health benefit plans to be used by the small
8 employer carrier.

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

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

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

24 (b) A health benefit plan must waive any time period
25 applicable to a preexisting condition exclusion or

1 limitation period with respect to particular services for
2 the period of time an individual was previously covered by
3 qualifying previous coverage that provided benefits with
4 respect to those services if the qualifying previous
5 coverage was continuous to a date not less than 30 days
6 prior to the submission of an application for new coverage.
7 This subsection (3)(b) does not preclude application of any
8 waiting period applicable to all new enrollees under the
9 health benefit plan.

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

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

25 (ii) A small employer carrier may vary the application

1 of minimum participation requirements and minimum employer
2 contribution requirements only by the size of the small
3 employer group.

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

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

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

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

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

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

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

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

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

25 (b) (i) In selecting the members of the board, the

1 commissioner shall include representatives of small
 2 employers, small employer carriers, and other qualified
 3 individuals, as determined by the commissioner. At least six
 4 of the members of the board must be representatives of small
 5 employer carriers, one from each of the five small employer
 6 carriers with the highest annual premium volume derived from
 7 health benefit plans issued to small employers in Montana in
 8 the previous calendar year and one from the remaining small
 9 employer carriers. One member of the board must be a person
 10 licensed, certified, or otherwise authorized by the laws of
 11 Montana to provide health care in the ordinary course of
 12 business or in the practice of a profession. One member of
 13 the board must be a small employer who is not active in the
 14 health care or insurance fields. One member of the board
 15 must be a representative of the general public who is
 16 employed by a small employer and is not employed in the
 17 health care or insurance fields.

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

25 (iii) A vacancy on the board must be filled by the

1 commissioner. The commissioner may remove a board member for
 2 cause.

3 (3) Within [60 days of the effective date of this
 4 section] AND ON OR BEFORE MARCH 1 OF EACH YEAR AFTER THAT
 5 DATE, each ~~small-employer~~ ASSESSABLE carrier shall file with
 6 the commissioner the carrier's net health insurance premium
 7 derived from health benefit plans issued ~~to-small-employers~~
 8 in this state in the previous calendar year.

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

22 (5) If the board fails to submit a suitable plan of
 23 operation within 180 days after its appointment, the
 24 commissioner shall, after notice and hearing, promulgate and
 25 adopt a temporary plan of operation. The commissioner shall

1 amend or rescind any temporary plan adopted under this
2 subsection at the time a plan of operation is submitted by
3 the board and approved by the commissioner.

4 (6) The plan of operation must:

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

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

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

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

17 (E) ESTABLISH PROCEDURES FOR ALLOCATING A PORTION OF
18 PREMIUMS COLLECTED FROM REINSURING CARRIERS TO FUND
19 ADMINISTRATIVE EXPENSES INCURRED OR TO BE INCURRED BY THE
20 PROGRAM; AND

21 ~~te)(F)~~ provide for any additional matters necessary for
22 the implementation and administration of the program.

23 (7) The program ~~must--have~~ HAS the general powers and
24 authority granted under the laws of this state to insurance
25 companies and health maintenance organizations licensed to

1 transact business, except the power to issue health benefit
2 plans directly to either groups or individuals. In addition,
3 the program ~~must-have-the-specific-authority-to~~ MAY:

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

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

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

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

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

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

25 (g) appoint appropriate legal, actuarial, and other

committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program; and

(H) TO THE EXTENT PERMITTED BY FEDERAL LAW AND IN ACCORDANCE WITH SUBSECTION (11)(C), MAKE ANNUAL FISCAL YEAREND ASSESSMENTS AGAINST ASSESSABLE CARRIERS AND MAKE INTERIM ASSESSMENTS TO FUND CLAIMS INCURRED BY THE PROGRAM; AND

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

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

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

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

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following

the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

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

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

(e) A small employer carrier may terminate reinsurance

with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

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

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

(9) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (9)(b) to determine the premium rates for the program. The base reinsurance premium

rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under [sections 22 through 36].

(b) Premiums for the program are as follows:

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

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

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

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

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

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

(b) ~~A net loss for the year must be reimbursed by the commissioner from funds specifically appropriated for that purpose.~~ TO THE EXTENT PERMITTED BY FEDERAL LAW, EACH ASSESSABLE CARRIER SHALL SHARE IN ANY NET LOSS OF THE PROGRAM FOR THE YEAR IN AN AMOUNT EQUAL TO THE RATIO OF THE TOTAL PREMIUMS EARNED IN THE PREVIOUS CALENDAR YEAR FROM HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY BY EACH ASSESSABLE CARRIER DIVIDED BY THE TOTAL PREMIUMS EARNED IN THE PREVIOUS CALENDAR YEAR FROM HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY BY ALL ASSESSABLE CARRIERS IN THE STATE.

(c) THE BOARD SHALL MAKE AN ANNUAL DETERMINATION IN ACCORDANCE WITH THIS SECTION OF EACH ASSESSABLE CARRIER'S LIABILITY FOR ITS SHARE OF THE NET LOSS OF THE PROGRAM AND,

EXCEPT AS OTHERWISE PROVIDED BY THIS SECTION, MAKE AN ANNUAL FISCAL YEAREND ASSESSMENT AGAINST EACH ASSESSABLE CARRIER TO THE EXTENT OF THAT LIABILITY. IF APPROVED BY THE COMMISSIONER, THE BOARD MAY ALSO MAKE INTERIM ASSESSMENTS AGAINST ASSESSABLE CARRIERS TO FUND CLAIMS INCURRED BY THE PROGRAM. ANY INTERIM ASSESSMENT MUST BE CREDITED AGAINST THE AMOUNT OF ANY FISCAL YEAREND ASSESSMENT DUE OR TO BE DUE FROM AN ASSESSABLE CARRIER. PAYMENT OF A FISCAL YEAREND OR INTERIM ASSESSMENT IS DUE WITHIN 30 DAYS OF RECEIPT BY THE ASSESSABLE CARRIER OF WRITTEN NOTICE OF THE ASSESSMENT. AN ASSESSABLE CARRIER THAT CEASES DOING BUSINESS WITHIN THE STATE IS LIABLE FOR ASSESSMENTS UNTIL THE END OF THE CALENDAR YEAR IN WHICH THE ASSESSABLE CARRIER CEASED DOING BUSINESS. THE BOARD MAY DETERMINE NOT TO ASSESS AN ASSESSABLE CARRIER IF THE ASSESSABLE CARRIER'S LIABILITY DETERMINED IN ACCORDANCE WITH THIS SECTION DOES NOT EXCEED \$10.

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

(13) The board, as part of the plan of operation, shall

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

(14) The program is exempt from taxation.

(15) ON OR BEFORE MARCH 1 OF EACH YEAR, THE COMMISSIONER SHALL EVALUATE THE OPERATION OF THE PROGRAM AND REPORT TO THE GOVERNOR AND THE LEGISLATURE IN WRITING THE RESULTS OF THE EVALUATION. THE REPORT MUST INCLUDE AN ESTIMATE OF FUTURE COSTS OF THE PROGRAM, ASSESSMENTS NECESSARY TO PAY THOSE COSTS, THE APPROPRIATENESS OF PREMIUMS CHARGED BY THE PROGRAM, THE LEVEL OF INSURANCE RETENTION UNDER THE PROGRAM, THE COST OF COVERAGE OF SMALL EMPLOYERS, AND ANY RECOMMENDATIONS FOR CHANGE TO THE PLAN OF OPERATION.

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

(A) ONE HEALTH CARE PROVIDER;

(B) ONE REPRESENTATIVE OF THE HEALTH INSURANCE INDUSTRY;

(C) ONE EMPLOYEE OF A SMALL EMPLOYER;

(D) ONE MEMBER OF A LABOR UNION; AND

(E) ONE REPRESENTATIVE OF THE GENERAL PUBLIC WHO MAY NOT REPRESENT THE PERSONS OR GROUPS LISTED IN SUBSECTIONS (1)(A) THROUGH (1)(D).

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

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

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

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

1 (ii) case management;
 2 (iii) selective contracting with hospitals, physicians,
 3 and other health care providers;
 4 (iv) reasonable benefit differentials applicable to
 5 providers that participate or do not participate in
 6 arrangements using restricted network provisions; and
 7 (v) other managed care provisions.
 8 (c) The committee shall submit the health benefit plans
 9 described in subsections (3)(a) and (3)(b) to the
 10 commissioner for---approval within 180 days after the
 11 appointment of the committee. THE COMMISSIONER SHALL ADOPT
 12 AS A RULE PURSUANT TO TITLE 2, CHAPTER 4, PART 3, THE HEALTH
 13 BENEFIT PLANS REQUIRED BY [SECTION 29(1)] TO BE OFFERED IN
 14 THIS STATE.

15 NEW SECTION. Section 32. Periodic market evaluation --
 16 report. The board, in consultation with members of the
 17 committee, shall study and report at least every 3 years to
 18 the commissioner on the effectiveness of [sections 22
 19 through 36]. The report must analyze the effectiveness of
 20 [sections 22 through 36] in promoting rate stability,
 21 product availability, and coverage affordability. The report
 22 may contain recommendations for actions to improve the
 23 overall effectiveness, efficiency, and fairness of the small
 24 employer health insurance markets. The report must address
 25 whether carriers and producers are fairly and actively

1 marketing or issuing health benefit plans to small employers
 2 in fulfillment of the purposes of [sections 22 through 36].
 3 The report may contain recommendations for market conduct or
 4 other regulatory standards or action.

5 NEW SECTION. Section 33. Waiver of certain laws. A law
 6 that requires the inclusion of a specific category of
 7 licensed health care practitioner--does PRACTITIONERS AND A
 8 LAW THAT REQUIRES THE COVERAGE OF A HEALTH CARE SERVICE OR
 9 BENEFIT DO not apply to a basic health benefit plan
 10 delivered or issued for delivery to small employers in this
 11 state pursuant to [sections 22 through 36] BUT DO APPLY TO A
 12 STANDARD HEALTH BENEFIT PLAN DELIVERED OR ISSUED FOR
 13 DELIVERY TO SMALL EMPLOYERS IN THIS STATE PURSUANT TO
 14 [SECTIONS 22 THROUGH 36].

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

19 NEW SECTION. Section 35. Standards to ensure fair
 20 marketing. (1) Each small employer carrier shall actively
 21 market health benefit plan coverage, including the basic and
 22 standard health benefit plans, to eligible small employers
 23 in the state. If a small employer carrier denies coverage
 24 other than the basic or standard health benefit plans to a
 25 small employer on the basis of claims experience of the

1 small employer or the health status or claims experience of
 2 its employees or dependents, the small employer carrier
 3 shall offer the small employer the opportunity to purchase a
 4 basic health benefit plan or a standard health benefit plan.

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

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

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

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

23 (3) (a) Except as provided in subsection (3)(b), a
 24 small employer carrier may not, directly or indirectly,
 25 enter into any contract, agreement, or arrangement with a

1 producer that provides for or results in the compensation
 2 paid to a producer for the sale of a health benefit plan to
 3 be varied because of the health status of the employer's
 4 employees or the claims experience, industry, occupation, or
 5 geographic location of the small employer.

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

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

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

24 (6) A small employer carrier or producer may not induce
 25 or otherwise encourage a small employer to separate or

1 otherwise exclude an employee from health coverage or
2 benefits provided in connection with the employee's
3 employment.

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

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

11 (9) (a) A violation of this section by a small employer
12 carrier or a producer is an unfair trade practice under
13 33-18-102.

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

21 NEW SECTION. Section 36. Restoration of terminated
22 coverage. The commissioner may promulgate rules to require
23 small employer carriers, as a condition of transacting
24 business with small employers in this state after [the
25 effective date of this section], to reissue a health benefit

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

8 NEW SECTION. SECTION 37. FINDING AND PURPOSE. THE
9 LEGISLATURE FINDS THAT THE GOALS OF CONTROLLING HEALTH CARE
10 COSTS AND IMPROVING THE QUALITY OF AND ACCESS TO HEALTH CARE
11 WILL BE SIGNIFICANTLY ENHANCED IN SOME CASES BY COOPERATIVE
12 AGREEMENTS AMONG HEALTH CARE FACILITIES. THE PURPOSE OF
13 [SECTIONS 37 THROUGH 44] IS TO PROVIDE THE STATE, THROUGH
14 THE AUTHORITY, WITH DIRECT SUPERVISION AND CONTROL OVER THE
15 IMPLEMENTATION OF COOPERATIVE AGREEMENTS AMONG HEALTH CARE
16 FACILITIES FOR WHICH CERTIFICATES OF PUBLIC ADVANTAGE ARE
17 GRANTED. IT IS THE INTENT OF THE LEGISLATURE THAT
18 SUPERVISION AND CONTROL OVER THE IMPLEMENTATION OF THESE
19 AGREEMENTS SUBSTITUTE STATE REGULATION OF FACILITIES FOR
20 COMPETITION BETWEEN FACILITIES AND THAT THIS REGULATION HAVE
21 THE EFFECT OF GRANTING THE PARTIES TO THE AGREEMENTS STATE
22 ACTION IMMUNITY FOR ACTIONS THAT MIGHT OTHERWISE BE
23 CONSIDERED TO BE IN VIOLATION OF STATE OR FEDERAL, OR BOTH,
24 ANTITRUST LAWS.

25 NEW SECTION. SECTION 38. COOPERATIVE AGREEMENTS

1 ALLOWED. A HEALTH CARE FACILITY MAY ENTER INTO A COOPERATIVE
 2 AGREEMENT WITH ONE OR MORE HEALTH CARE FACILITIES.

3 NEW SECTION. SECTION 39. CERTIFICATE OF PUBLIC
 4 ADVANTAGE -- STANDARDS FOR CERTIFICATION -- TIME FOR ACTION
 5 BY AUTHORITY. (1) PARTIES TO A COOPERATIVE AGREEMENT MAY
 6 APPLY TO THE AUTHORITY FOR A CERTIFICATE OF PUBLIC
 7 ADVANTAGE. THE APPLICATION FOR A CERTIFICATE MUST INCLUDE A
 8 COPY OF THE PROPOSED OR EXECUTED AGREEMENT, A DESCRIPTION OF
 9 THE SCOPE OF THE COOPERATION CONTEMPLATED BY THE AGREEMENT,
 10 AND THE AMOUNT, NATURE, SOURCE, AND RECIPIENT OF ANY
 11 CONSIDERATION PASSING TO ANY PERSON UNDER THE TERMS OF THE
 12 AGREEMENT.

13 (2) THE AUTHORITY SHALL HOLD A PUBLIC HEARING ON THE
 14 APPLICATION FOR A CERTIFICATE BEFORE ACTING UPON THE
 15 APPLICATION. THE AUTHORITY MAY NOT ISSUE A CERTIFICATE
 16 UNLESS THE AUTHORITY FINDS THAT THE AGREEMENT IS LIKELY TO
 17 RESULT IN LOWER HEALTH CARE COSTS OR IN GREATER ACCESS TO OR
 18 QUALITY OF HEALTH CARE THAN WOULD OCCUR WITHOUT THE
 19 AGREEMENT. IF THE AUTHORITY DENIES AN APPLICATION FOR A
 20 CERTIFICATE FOR AN EXECUTED AGREEMENT, THE AGREEMENT IS VOID
 21 UPON THE DECISION OF THE AUTHORITY NOT TO ISSUE THE
 22 CERTIFICATE. PARTIES TO A VOID AGREEMENT MAY NOT IMPLEMENT
 23 OR CARRY OUT THE AGREEMENT.

24 (3) THE AUTHORITY SHALL DENY THE APPLICATION FOR A
 25 CERTIFICATE OR ISSUE A CERTIFICATE WITHIN 90 DAYS OF RECEIPT

1 OF A COMPLETED APPLICATION.

2 NEW SECTION. SECTION 40. RECONSIDERATION BY AUTHORITY.

3 (1) IF THE AUTHORITY DENIES AN APPLICATION AND REFUSES TO
 4 ISSUE A CERTIFICATE, A PARTY TO THE AGREEMENT MAY REQUEST
 5 THAT THE AUTHORITY RECONSIDER ITS DECISION. THE AUTHORITY
 6 SHALL RECONSIDER ITS DECISION IF THE PARTY APPLYING FOR
 7 RECONSIDERATION SUBMITS THE REQUEST TO THE AUTHORITY IN
 8 WRITING WITHIN 30 CALENDAR DAYS OF THE AUTHORITY'S DECISION
 9 TO DENY THE INITIAL APPLICATION.

10 (2) THE AUTHORITY SHALL HOLD A PUBLIC HEARING ON THE
 11 APPLICATION FOR RECONSIDERATION. THE HEARING MUST BE HELD
 12 WITHIN 30 DAYS OF RECEIPT OF THE REQUEST FOR RECONSIDERATION
 13 UNLESS THE PARTY APPLYING FOR RECONSIDERATION AGREES TO A
 14 HEARING AT A LATER TIME. THE HEARING MUST BE HELD PURSUANT
 15 TO 2-4-604.

16 (3) THE AUTHORITY SHALL MAKE A DECISION TO DENY THE
 17 APPLICATION OR TO ISSUE THE CERTIFICATE WITHIN 30 DAYS OF
 18 THE CONCLUSION OF THE HEARING REQUIRED BY SUBSECTION (2).
 19 THE DECISION OF THE AUTHORITY MUST BE PART OF WRITTEN
 20 FINDINGS OF FACT AND CONCLUSIONS OF LAW SUPPORTING THE
 21 DECISION. THE FINDINGS, CONCLUSIONS, AND DECISION MUST BE
 22 SERVED UPON THE APPLICANT FOR RECONSIDERATION.

23 NEW SECTION. SECTION 41. REVOCATION OF CERTIFICATE BY
 24 AUTHORITY. (1) THE AUTHORITY SHALL REVOKE A CERTIFICATE
 25 PREVIOUSLY GRANTED BY IT IF THE AUTHORITY DETERMINES THAT

1 THE COOPERATIVE AGREEMENT IS NOT RESULTING IN LOWER HEALTH
 2 CARE COSTS OR GREATER ACCESS TO OR QUALITY OF HEALTH CARE
 3 THAN WOULD OCCUR IN ABSENCE OF THE AGREEMENT.

4 (2) A CERTIFICATE MAY NOT BE REVOKED BY THE AUTHORITY
 5 WITHOUT GIVING NOTICE AND AN OPPORTUNITY FOR A HEARING
 6 BEFORE THE AUTHORITY AS FOLLOWS:

7 (A) WRITTEN NOTICE OF THE PROPOSED REVOCATION MUST BE
 8 GIVEN TO THE PARTIES TO THE AGREEMENT FOR WHICH THE
 9 CERTIFICATE WAS ISSUED AT LEAST 120 DAYS BEFORE THE
 10 EFFECTIVE DATE OF THE PROPOSED REVOCATION.

11 (B) A HEARING MUST BE PROVIDED PRIOR TO REVOCATION IF A
 12 PARTY TO THE AGREEMENT SUBMITS A WRITTEN REQUEST FOR A
 13 HEARING TO THE AUTHORITY WITHIN 30 CALENDAR DAYS AFTER
 14 NOTICE IS MAILED TO THE PARTY UNDER SUBSECTION (2)(A).

15 (C) WITHIN 30 CALENDAR DAYS OF RECEIPT OF THE REQUEST
 16 FOR A HEARING, THE AUTHORITY SHALL HOLD A PUBLIC HEARING TO
 17 DETERMINE WHETHER OR NOT TO REVOKE THE CERTIFICATE. THE
 18 HEARING MUST BE HELD IN ACCORDANCE WITH 2-4-604.

19 (3) THE AUTHORITY SHALL MAKE ITS FINAL DECISION AND
 20 SERVE THE PARTIES WITH WRITTEN FINDINGS OF FACT AND
 21 CONCLUSIONS OF LAW IN SUPPORT OF ITS DECISION WITHIN 30 DAYS
 22 AFTER THE CONCLUSION OF THE HEARING OR, IF NO HEARING IS
 23 REQUESTED, WITHIN 30 DAYS OF THE DATE OF EXPIRATION OF THE
 24 TIME TO REQUEST A HEARING.

25 (4) IF A CERTIFICATE OF PUBLIC ADVANTAGE IS REVOKED BY

1 THE AUTHORITY, THE AGREEMENT FOR WHICH THE CERTIFICATE WAS
 2 ISSUED IS TERMINATED.

3 NEW SECTION. SECTION 42. APPEAL. A PARTY TO A
 4 COOPERATIVE AGREEMENT MAY APPEAL, IN THE MANNER PROVIDED IN
 5 TITLE 2, CHAPTER 4, PART 7, A FINAL DECISION BY THE
 6 AUTHORITY TO DENY AN APPLICATION FOR A CERTIFICATE OR A
 7 DECISION BY THE AUTHORITY TO REVOKE A CERTIFICATE. A
 8 REVOCATION OF A CERTIFICATE PURSUANT TO [SECTION 41] DOES
 9 NOT BECOME FINAL UNTIL THE TIME FOR APPEAL HAS EXPIRED. IF A
 10 DECISION TO REVOKE A CERTIFICATE IS APPEALED, THE DECISION
 11 IS STAYED PENDING RESOLUTION OF THE APPEAL BY THE COURTS.

12 NEW SECTION. SECTION 43. RECORD OF AGREEMENTS TO BE
 13 KEPT. THE AUTHORITY SHALL KEEP A COPY OF COOPERATIVE
 14 AGREEMENTS FOR WHICH A CERTIFICATE IS IN EFFECT PURSUANT TO
 15 [SECTIONS 37 THROUGH 44]. A PARTY TO A COOPERATIVE AGREEMENT
 16 WHO TERMINATES THE AGREEMENT SHALL NOTIFY THE AUTHORITY IN
 17 WRITING OF THE TERMINATION WITHIN 30 DAYS AFTER THE
 18 TERMINATION.

19 NEW SECTION. SECTION 44. RULEMAKING. THE AUTHORITY
 20 SHALL ADOPT RULES TO IMPLEMENT [SECTIONS 37 THROUGH 43]. THE
 21 RULES SHALL INCLUDE RULES:

22 (1) SPECIFYING THE FORM AND CONTENT OF APPLICATIONS FOR
 23 A CERTIFICATE;

24 (2) SPECIFYING NECESSARY DETAILS FOR RECONSIDERATION OF
 25 DENIAL OF CERTIFICATES, REVOCATIONS OF CERTIFICATES,

1 HEARINGS REQUIRED OR AUTHORIZED BY [SECTIONS 37 THROUGH 43],
 2 AND APPEALS; AND

3 (3) TO EFFECT THE ACTIVE SUPERVISION BY THE AUTHORITY
 4 OF AGREEMENTS BETWEEN HEALTH CARE FACILITIES. THESE RULES
 5 MAY INCLUDE REPORTING REQUIREMENTS FOR PARTIES TO AN
 6 AGREEMENT FOR WHICH A CERTIFICATE IS IN EFFECT.

7 NEW SECTION. Section 45. Codification instructions.

8 (1) [Sections 1 through 20 AND 37 THROUGH 44] are intended
 9 to be codified as an integral part of Title 50, and the
 10 provisions of Title 50 apply to [sections 1 through 20 AND
 11 37 THROUGH 44].

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

15 NEW SECTION. SECTION 46. SEVERABILITY. IF A PART OF
 16 [THIS ACT] IS INVALID, ALL VALID PARTS THAT ARE SEVERABLE
 17 FROM THE INVALID PART REMAIN IN EFFECT. IF A PART OF [THIS
 18 ACT] IS INVALID IN ONE OR MORE OF ITS APPLICATIONS, THE PART
 19 REMAINS IN EFFECT IN ALL VALID APPLICATIONS THAT ARE
 20 SEVERABLE FROM THE INVALID APPLICATIONS.

21 NEW SECTION. Section 47. Effective dates. (1)

22 [Sections 1 through 20~~7~~ AND 44 THROUGH 46 and this
 23 section] are effective on passage and approval.

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

25 (3) [Sections 22 through 28, 35, AND 36] are effective

1 January 1, 1994.

2 (4) [SECTIONS 30 THROUGH 34] ARE EFFECTIVE JULY 1,

3 1993.

-End-

Conference Committee
on Senate Bill No. 285
Report No. 1, April 19, 1993

April 20, 1993
Page 2 of 2

Page 1 of 2

Mr. President and Mr. Speaker:

We, your Conference Committee on Senate Bill No. 285, met and considered: House amendments to Senate Bill No. 285. We recommend that Senate Bill No. 285 (reference copy - salmon) be amended as follows:

1. Page 7, lines 9 and 10.
Strike: "SIMILAR TO THE CERTIFICATE OF NEED SYSTEM BY WHICH"
Insert: "to control"
Strike: "ARE CONTROLLED"
2. Page 7, lines 16 through 21.
Strike: subsection (F) in its entirety
3. Page 15, lines 19 and 20.
Strike: "EACH STATEWIDE PLAN MUST INCLUDE INCENTIVES FOR MARKET CONTROL."
4. Page 17, lines 14 and 15.
Strike: " PROVIDE MARKET CONTROL,"
5. Page 17, line 22.
Strike: "(P) INCENTIVES FOR MARKET CONTROL;"
Renumber: subsequent subsections
6. Page 19, line 9.
Strike: "AND AN INDIVIDUAL'S CHOICE OF SERVICES"
7. Page 40, line 8.
Following: "INSURANCE,"
Insert: "excluding"
8. Page 46, line 22.
Following: "OR"
Insert: "(a)"
9. Page 46, line 24.
Following: "36]"
Insert: ;
(b) does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group;
Following: "AND"
Insert: ;
(c)

ADOPT

REJECT

10. Page 47, line 1.
Following: "GROUP"
Insert: ,""

And that this Conference Committee report be adopted.

For the Senate:

Ever Franklin
Senator Franklin, Chair

B.C. Brown
Senator Brown

Dorothy Eck
Senator Eck

For the House:

Burt Simon
Representative Simon, Chair

Sam Nelson
Representative T. Nelson

Shirley
Representative S. Rice

M
Am. Coord.
N
Sec. of Senate

861723CC.Saa

CCR #1
SB 285
861723CC.Saa

SENATE BILL NO. 285

INTRODUCED BY FRANKLIN, B. BROWN, JACOBSON, SCHYE,
 BIANCHI, HARPER, JERGESON, RYAN, LYNCH, HALLIGAN,
 VAN VALKENBURG, MERCER, CRIPPEN, SQUIRES, GRINDE, COBB,
 CHRISTIAENS, BLAYLOCK, L. NELSON, ECK, STRIZICH, TOOLE,
 COCCHIARELLA, MCCARTHY, WILSON, WATERMAN, BECK, KLAMPE,
 DOWELL, RUSSELL, STANFORD, TUSS, DOLEZAL, DOHERTY,
 PAVLOVICH, WEEDING, BRUSKI-MAUS, NATHE, VAUGHN,
 WELDON, KENNEDY, WILSON, BARTLETT,
 SIMPKINS, HOCKETT, YELLOWTAIL, J. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR UNIVERSAL
 HEALTH CARE ACCESS, HEALTH CARE PLANNING, AND COST
 CONTAINMENT; CREATING THE MONTANA HEALTH CARE AUTHORITY;
 PROVIDING FOR THE POWERS AND DUTIES OF THE AUTHORITY;
 REQUIRING A STATEWIDE UNIVERSAL HEALTH CARE ACCESS PLAN;
 REQUIRING A HEALTH CARE RESOURCE MANAGEMENT PLAN; PROVIDING
 FOR SIMPLIFICATION OF HEALTH CARE EXPENSES BILLING;
 REQUIRING THE AUTHORITY TO CONDUCT A STUDY AND REPORT ON
 LONG-TERM CARE; REQUIRING THE AUTHORITY TO ESTABLISH HEALTH
 PLANNING REGIONS AND BOARDS REQUIRING DEVELOPMENT OF UNIFORM
CLAIM FORMS AND PROCEDURES; REQUIRING THE AUTHORITY TO
CONDUCT STUDIES CONCERNING PRESCRIPTION DRUGS, LONG-TERM
CARE, AND THE CERTIFICATE OF NEED PROCESS; CREATING HEALTH
CARE PLANNING REGIONS; REQUIRING ESTABLISHMENT OF REGIONAL

HEALTH CARE PLANNING BOARDS; PROVIDING FOR THE POWERS AND
DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A
UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR HEALTH
INSURANCE REFORM REQUIRING HEALTH INSURER COST MANAGEMENT
PLANS; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF
THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL
SCIENCES RELATING TO VITAL STATISTICS STATE HEALTH PLANNING;
PROVIDING A SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY
ACT; ALLOWING HEALTH CARE FACILITIES TO ENTER INTO
COOPERATIVE AGREEMENTS WITH THE APPROVAL AND SUPERVISION OF
THE AUTHORITY; AMENDING SECTION 50-15-101 50-1-201, MCA; AND
PROVIDING EFFECTIVE DATES."

STATEMENT OF INTENT

A statement of legislative intent is required for this
 bill because {section 10} requires the Montana health care
 authority to adopt rules establishing a maximum of five
 health care planning regions, to establish regional health
 care planning boards within those regions, and to establish
 a procedure for selection of regional board members. The
 legislature intends that the rules establishing the health
 care planning regions be based primarily upon the geographic
 health care referral patterns by which health care providers
 refer patients to specialists or larger health care
 facilities. These rules should also consider communication

and-transportation-patterns-and-natural--barriers--to--these patterns. The rules establishing the boards must specify the number--of--members,--any--relevant--qualifications, and the operations-and-duties-of-the-boards-and-must-provide--for--a funding-mechanism-by-grant-from-the-authority. The procedure for--selection--of-the-board-members-must-provide-for-public notice-of-the-selection-process.

A-statement-of-intent-is-also-required-because--{section 12}--requires--the--authority-to-adopt-rules-relating-to-the unified-health-care-data-base. The--authority's--rules--must specify-in-comprehensive-detail-what-information-is-required to--be--provided--by--health-care-providers-and-the-times-at which-the-information-is-to-be-provided. The rules must also provide-for-audit-procedures-to-determine--the--accuracy--of the--filed--data. The--confidentiality--provisions--must-be consistent---with---other---state---laws---governing---the confidentiality---of---public---records,--including--medical records, and must apply to employees of the authority and to others-receiving-or-using-records-in-the-data-base.

A-statement-of-intent-is-also-required-because--{section 13}--requires--the--commissioner-of-insurance-to-adopt-rules governing-small-employer-group-health-plans. In--determining the--basic--benefits--package, the--commissioner-shall-make objective--determinations,--supported--by--available---data, concerning-the-type-of-benefits-required-and-shall-determine

that--the--benefits-to-be-required-are-cost-effective. (1) A STATEMENT OF LEGISLATIVE INTENT IS REQUIRED FOR THIS BILL BECAUSE:

{1}(A) [SECTION 4] AUTHORIZES THE MONTANA HEALTH CARE AUTHORITY TO ADOPT RULES NECESSARY TO IMPLEMENT [SECTIONS 1 THROUGH 20]. IN ADDITION TO THOSE RULEMAKING MATTERS ADDRESSED BELOW, THE AUTHORITY MAY ADOPT RULES GOVERNING SUCH MATTERS AS ITS MEETINGS, PUBLIC HEARINGS, AND RULES OF PROCEDURE AND RULES OF ETHICAL CONDUCT GOVERNING ITS MEMBERS.

{2}(B) [SECTION 17] REQUIRES THE MONTANA HEALTH CARE AUTHORITY TO ADOPT RULES TO ESTABLISH REGIONAL HEALTH CARE PLANNING BOARDS WITHIN THE HEALTH CARE PLANNING REGIONS ESTABLISHED IN [SECTION 17] AND TO ESTABLISH A PROCEDURE FOR SELECTION OF REGIONAL BOARD MEMBERS. THE RULES ESTABLISHING THE BOARDS MUST SPECIFY THE NUMBER OF MEMBERS, ANY RELEVANT QUALIFICATIONS, AND THE OPERATIONS AND DUTIES OF THE BOARDS AND MUST PROVIDE FOR A FUNDING MECHANISM BY GRANT FROM THE AUTHORITY. IN ADDITION, THE RULES MUST PROVIDE FOR CONSIDERATION OF A BALANCE BETWEEN RURAL AND URBAN INTERESTS IN THE SELECTION OF REGIONAL BOARD MEMBERS. THE PROCEDURE FOR SELECTION OF THE BOARD MEMBERS MUST PROVIDE FOR PUBLIC NOTICE OF THE SELECTION PROCESS.

{3}(C) [SECTION 10] GRANTS THE COMMISSIONER OF INSURANCE THE AUTHORITY TO ADOPT RULES SPECIFYING UNIFORM

1 HEALTH INSURANCE CLAIM FORMS AND PROCEDURES. THE FORMS
 2 SHOULD BE BASED UPON EXISTING FORMATS, BE AS SHORT AS
 3 POSSIBLE, AND BE COMPATIBLE WITH ELECTRONIC DATA
 4 TRANSMISSION.

5 (4)(D) [SECTION 19] REQUIRES THE AUTHORITY TO ADOPT
 6 RULES RELATING TO THE UNIFIED HEALTH CARE DATA BASE. THE
 7 AUTHORITY'S RULES MUST SPECIFY IN COMPREHENSIVE DETAIL WHAT
 8 INFORMATION IS REQUIRED TO BE PROVIDED BY HEALTH CARE
 9 PROVIDERS AND THE TIMES AT WHICH THE INFORMATION IS TO BE
 10 PROVIDED. THE RULES MUST ALSO PROVIDE FOR AUDIT PROCEDURES
 11 TO DETERMINE THE ACCURACY OF THE FILED DATA. THE
 12 CONFIDENTIALITY PROVISIONS MUST BE CONSISTENT WITH OTHER
 13 STATE LAWS GOVERNING THE CONFIDENTIALITY OF PUBLIC RECORDS,
 14 INCLUDING MEDICAL RECORDS, AND MUST APPLY TO EMPLOYEES OF
 15 THE AUTHORITY AND TO OTHERS RECEIVING OR USING RECORDS IN
 16 THE DATA BASE.

17 (5)(E) [SECTIONS 23, 26, 27, 30, 31, AND 34 THROUGH 36]
 18 REQUIRE THE COMMISSIONER OF INSURANCE TO ADOPT RULES
 19 GOVERNING SMALL EMPLOYER GROUP HEALTH PLANS. IN DETERMINING
 20 THE BASIC BENEFITS PACKAGE, THE COMMISSIONER SHALL MAKE
 21 OBJECTIVE DETERMINATIONS, SUPPORTED BY AVAILABLE DATA,
 22 CONCERNING THE TYPE OF BENEFITS REQUIRED AND SHALL DETERMINE
 23 THAT THE BENEFITS TO BE REQUIRED ARE COST-EFFECTIVE PURSUANT
 24 TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE
 25 COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION

1 PERIOD TO ALLOW SMALL EMPLOYER CARRIERS TO COMPLY WITH
 2 CERTAIN PROVISIONS OF THE ACT. THE COMMISSIONER MAY APPROVE
 3 THE ESTABLISHMENT OF ADDITIONAL CLASSES OF BUSINESSES ONLY
 4 IF THE COMMISSIONER DETERMINES THAT THE ADDITIONAL CLASSES
 5 WOULD ENHANCE THE EFFICIENCY AND FAIRNESS OF THE SMALL
 6 EMPLOYER HEALTH INSURANCE MARKET. THE COMMISSIONER IS
 7 REQUIRED UNDER THE ACT TO ADOPT RULES TO IMPLEMENT AND
 8 ADMINISTER THE ACT.

9 (F) [SECTION 44] REQUIRES THE AUTHORITY TO ADOPT RULES
 10 IMPLEMENTING [SECTIONS 37 THROUGH 44]. THE RULES ADOPTED BY
 11 THE AUTHORITY MUST SPECIFY THE FORM AND CONTENT OF
 12 APPLICATIONS FOR CERTIFICATES OF PUBLIC ADVANTAGE; DETAILS
 13 OF THE RECONSIDERATION, REVOCATION, HEARING, AND APPEAL
 14 PROCESSES; AND OTHER MATTERS AS THE AUTHORITY DETERMINES
 15 NECESSARY. THE RULES THAT ARE ADOPTED BY THE AUTHORITY MUST
 16 ALSO PROVIDE THE AUTHORITY WITH DIRECT SUPERVISION AND
 17 CONTROL OVER THE IMPLEMENTATION OF COOPERATIVE AGREEMENTS
 18 BETWEEN FACILITIES.

19 (2) IN PREPARING THE PLAN REQUIRED BY [SECTION 5], THE
 20 AUTHORITY SHALL CONSIDER THE FOLLOWING MATTERS FOR THE
 21 FOLLOWING FEATURES OF THE PLAN:

22 (A) A UNIFIED HEALTH CARE BUDGET. THE AUTHORITY SHALL
 23 CONSIDER THE DEVELOPMENT OF A STATE HEALTH CARE BUDGET BASED
 24 UPON THE BUDGETS SUBMITTED BY THE REGIONAL HEALTH CARE
 25 PLANNING BOARDS.

(B) CAPS FOR PROVIDER EXPENDITURES. THE AUTHORITY SHALL CONSIDER A PROCESS FOR ADOPTING MANDATORY LIMITS ON PROVIDER EXPENSES, INCLUDING FEES AND SALARIES.

(C) GLOBAL BUDGETING FOR ALL HEALTH CARE SPENDING. THE AUTHORITY SHALL CONSIDER ADOPTING A BUDGETING PROCESS, WITH PUBLIC INVOLVEMENT, BY WHICH A UNIFIED HEALTH CARE BUDGET IS DETERMINED.

(D) CONTROLLED CAPITAL EXPENDITURES. THE AUTHORITY SHALL CONSIDER ADOPTING A SYSTEM ~~SIMILAR TO THE CERTIFICATE OF NEED SYSTEM BY WHICH TO CONTROL CAPITAL EXPENDITURES ARE CONTROLLED.~~

(E) BINDING CAP ON OVERALL EXPENDITURES. THE AUTHORITY SHALL CONSIDER ADOPTING MANDATORY LIMITS ON ALL TYPES OF EXPENDITURES OF HEALTH CARE PROVIDERS, INCLUDING CAPITAL EXPENDITURES, SMALL EQUIPMENT PURCHASES, PERSONNEL COSTS, AND ALL OTHER TYPES OF OPERATING COSTS.

~~(F) MARKET CONTROL. THE AUTHORITY SHALL CONSIDER THE DEVELOPMENT OF A STATE HEALTH CARE PLAN BASED UPON THE PREFERENCES AND NEEDS OF THE HEALTH CARE CONSUMER. INCENTIVES FOR MARKET CONTROL SHOULD INCLUDE MECHANISMS THAT ENCOURAGE HEALTH CARE PROVIDERS TO RESPOND TO PREFERENCES AND NEEDS OF HEALTH CARE CONSUMERS.~~

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

(Refer to Introduced Bill)

Strike everything after the enacting clause and insert:

NEW SECTION. Section 1. State health care policy. (1)

It is the policy of the state of Montana to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary to develop a health care system that is integrated and subject to the direction and oversight of a single state agency. Comprehensive health planning through the application of a statewide health care resource management plan that is linked to a unified health care budget for Montana is essential.

(2) It is further the policy of the state of Montana that the health care system should:

(a) maintain and improve the quality of health care services offered to Montanans;

(b) contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Montanans' income or the money available for other services required to ensure the health, safety, and welfare of Montanans;

(c) avoid unnecessary duplication in the development and offering of health care facilities and services;

(d) encourage regional and local participation in decisions about health care delivery, financing, and provider supply;

(E) FACILITATE UNIVERSAL ACCESS TO HEALTH SCIENCES INFORMATION;

(F) PROMOTE RATIONAL ALLOCATION OF HEALTH CARE RESOURCES IN THE STATE; AND

(G) FACILITATE UNIVERSAL ACCESS TO PREVENTIVE AND MEDICALLY NECESSARY HEALTH CARE.

(3) IT IS FURTHER THE POLICY OF THE STATE OF MONTANA THAT REGARDLESS OF WHETHER OR WHAT FORM OF A HEALTH CARE ACCESS PLAN IS ADOPTED BY THE LEGISLATURE, THE HEALTH CARE AUTHORITY, HEALTH CARE PROVIDERS, AND OTHER PERSONS INVOLVED IN THE DELIVERY OF HEALTH CARE SERVICES NEED TO INCREASE THEIR EMPHASIS ON THE EDUCATION OF CONSUMERS OF HEALTH CARE SERVICES. CONSUMERS SHOULD BE EDUCATED CONCERNING THE HEALTH CARE SYSTEM, PAYMENT FOR SERVICES, ULTIMATE COSTS OF HEALTH CARE SERVICES, AND THE BENEFIT TO CONSUMERS GENERALLY OF PROVIDING ONLY SERVICES TO THE CONSUMER THAT ARE REASONABLE AND NECESSARY.

NEW SECTION. Section 2. Definitions. For the purposes of [sections 1 through 20 AND 37 THROUGH 44], the following definitions apply:

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

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

(3) "CERTIFICATE OF PUBLIC ADVANTAGE" OR "CERTIFICATE"

MEANS A WRITTEN CERTIFICATE ISSUED BY THE AUTHORITY AS EVIDENCE OF THE AUTHORITY'S INTENTION THAT THE IMPLEMENTATION OF A COOPERATIVE AGREEMENT, WHEN ACTIVELY SUPERVISED BY THE AUTHORITY, RECEIVE STATE ACTION IMMUNITY FROM PROSECUTION AS A VIOLATION OF STATE OR FEDERAL ANTITRUST LAWS.

(4) "COOPERATIVE AGREEMENT" OR "AGREEMENT" MEANS A WRITTEN AGREEMENT BETWEEN TWO OR MORE HEALTH CARE FACILITIES FOR THE SHARING, ALLOCATION, OR REFERRAL OF PATIENTS; PERSONNEL; INSTRUCTIONAL PROGRAMS; EMERGENCY MEDICAL SERVICES; SUPPORT SERVICES AND FACILITIES; MEDICAL, DIAGNOSTIC, OR LABORATORY FACILITIES OR PROCEDURES; OR OTHER SERVICES CUSTOMARILY OFFERED BY HEALTH CARE FACILITIES.

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

(6) "HEALTH CARE" INCLUDES BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

(7) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

1 †5†(8) "Health insurer" means any health insurance
2 company, health service corporation, health maintenance
3 organization, insurer providing disability insurance as
4 described in 33-1-207, and, to the extent permitted under
5 federal law, any administrator of an insured, self-insured,
6 or publicly funded health care benefit plan offered by
7 public and private entities.

8 †6†(9) "Health care provider" or "provider" means a
9 person who is licensed, certified, or otherwise authorized
10 by the laws of this state to provide health care in the
11 ordinary course of business or practice of a profession.

12 †7†(10) "Management plan" means the health care resource
13 management plan required by [section 8].

14 †8†(11) "Region" means one of the health care planning
15 regions created pursuant to [section 17].

16 †9†(12) "Statewide plan" means one of the statewide
17 universal health care access plans for access to health care
18 required by [section 5].

19 **NEW SECTION. Section 3. Montana health care authority**
20 -- allocation -- membership. (1) There is a Montana health
21 care authority.

22 (2) The authority is allocated to the department of
23 health and environmental sciences for administrative
24 purposes as provided in 2-15-121.

25 (3) The authority consists of five voting members

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

4 (a) Within 30 days of [the effective date of this
5 section], the majority SPEAKER and minority leader of the
6 house of representatives shall select an individual with
7 recognized expertise or interest, or both, in health care.
8 The majority SPEAKER and minority leader and the person
9 selected by them shall nominate by majority vote five
10 individuals for appointment to the authority.

11 (b) Within 30 days of [the effective date of this
12 section], the majority PRESIDENT and minority leader of the
13 senate shall select an individual with recognized expertise
14 or interest, or both, in health care. The majority PRESIDENT
15 and minority leader and the person selected by them shall
16 nominate by majority vote five individuals for appointment
17 to the authority.

18 (c) Within 90 days of [the effective date of this
19 section], the governor shall appoint from those nominated
20 under subsections (3)(a) and (3)(b) five individuals to the
21 authority.

22 (4) A vacancy must be filled in the same manner as
23 original appointments under subsection (3), except that one
24 individual must be selected under subsection (3)(a) and one
25 under subsection (3)(b). The governor shall appoint from

those nominated the individual to fill the vacancy.

(5) The presiding officer of the authority must be elected by majority vote of the voting members. The initial presiding officer must serve a 4-year term.

(6) Members serve terms of 4 years, except that of the members initially appointed, two members serve 4-year terms, two members serve 3-year terms, and one member serves a 2-year term, to be determined by lot.

(7) The directors of the department of social and rehabilitation services and the department of health and environmental sciences and the commissioner of insurance are nonvoting, ex officio members of the authority.

(8) THE ATTORNEY GENERAL IS AN EX OFFICIO, NONVOTING MEMBER OF THE AUTHORITY ONLY FOR THE PURPOSE OF THE AUTHORITY'S APPROVAL OR DENIAL OF CERTIFICATES OF PUBLIC ADVANTAGE, SUPERVISION OF COOPERATIVE AGREEMENTS, AND REVOCATION OF CERTIFICATES OF PUBLIC ADVANTAGE PURSUANT TO [SECTIONS 37 THROUGH 44].

~~(8)~~(9) A member shall acknowledge a direct conflict of interest in a proceeding in which the member has a personal or financial interest.

NEW SECTION. Section 4. Administration of health care authority -- reports -- compensation. (1) The authority shall employ a full-time executive director who shall conduct or direct the daily operation of the authority. The

executive director is exempt from the application of 2-18-204, 2-18-205, 2-18-207, and 2-18-1011 through 2-18-1013 and serves at the pleasure of the authority. The executive director is the chief administrative officer of the authority. The executive director has the power of a department head pursuant to 2-15-112, subject to the policies and procedures established by the authority.

(2) The authority may delegate its powers and assign the duties of the authority to the executive director as it may consider appropriate and necessary for the proper administration of the authority. However, the authority may not delegate its rulemaking powers under [sections 1 through 20].

(3) The authority may:

(a) employ professional and support staff necessary to carry out the functions of the authority; and

(b) employ consultants and contract with individuals and entities for the provision of services.

(4) The authority may:

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

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

(c) enter into contracts ~~and--perform---other---acts~~

1 necessary to accomplish the purposes of [sections 1 through
2 20].

3 (5) The authority shall report to the legislature and
4 the governor at least twice a year on its progress since the
5 last report in fulfilling the requirements of [sections 1
6 through 20]. Reports may be provided in a manner similar to
7 5-11-210 or in another manner determined by the authority.

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

10 (7) The authority shall make grants to the boards for
11 the operation of the boards. The authority shall provide for
12 uniform procedures for grant applications and budgets of the
13 boards.

14 NEW SECTION. Section 5. Statewide universal access
15 plans required. (1) On or before October 1, 1994, the
16 authority shall submit a report to the legislature that
17 contains the authority's recommendation for a statewide
18 universal health care access plan based on a single payor
19 system and a recommendation for a statewide universal access
20 plan based on a regulated multiple payor system. EACH
21 STATEWIDE-PLAN-MUST-INCLUDE-INCENTIVES-FOR--MARKET--CONTROL-
22 Each statewide plan must contain recommendations that, if
23 implemented, would provide for universally accessible,
24 medically necessary, and preventive health care by October
25 1, 1995. Both plans must be voted on by the 1995 legislature

1 ~~no-later-than-45--days--from--the--first--day--of--the--1995~~
2 ~~legislative--session.~~ The legislature may return one or both
3 plans to the authority for further development.

4 (2) For purposes of this section:

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

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

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

25 (2) Each statewide plan must include:

1 (a) guaranteed access to health care services for all
 2 residents of Montana;
 3 (b) a uniform system of health care benefits;
 4 (c) a unified health care budget;
 5 (d) portability of coverage, regardless of job status;
 6 (e) a broad-based, public or private financing
 7 mechanism to fund health care services;
 8 (F) CONSIDERATION OF THE LIMITATIONS OF PUBLIC FUNDING;
 9 ~~(f)(G)~~ a system capped for provider expenditures;
 10 ~~(f)(H)~~ global budgeting for all health care spending;
 11 ~~(f)(I)~~ controlled capital expenditures;
 12 ~~(f)(J)~~ a binding cap on overall expenditures;
 13 ~~(f)(K)~~ policymaking for the system as a whole and
 14 accountability within state government;
 15 ~~(f)(L)~~ incentives to be used to contain costs ~~---PROVIDE~~
 16 ~~MARKET-CONTROL~~ and direct resources;
 17 ~~(f)(M)~~ administrative efficiencies;
 18 ~~(f)(N)~~ the appropriate use of midlevel practitioners,
 19 such as physician's assistants and nurse practitioners;
 20 ~~(f)(O)~~ mechanisms for reducing the cost of prescription
 21 drugs, both as part of and as separate from the uniform
 22 benefit plan;
 23 ~~(P)---INCENTIVES-FOR-MARKET-CONTROL;~~
 24 ~~(f)(Q)(P)~~ integration, to the extent possible under
 25 federal and state law, of benefits provided under the health

1 care system with benefits provided by the Indian health
 2 service and the United States department of veteran affairs
 3 and benefits provided by the medicare and medicaid programs;
 4 and

5 ~~(P)(R)(Q)~~ an actuarially sound estimate of the costs of
 6 implementing the plan through the year 2005.

7 (3) NOTHING IN [SECTIONS 7 THROUGH 9 AND 11] OR THIS
 8 SECTION MAY BE INTERPRETED TO PREVENT MONTANA RESIDENTS FROM
 9 SEEKING HEALTH CARE SERVICES NOT PROVIDED IN EITHER OR BOTH
 10 STATEWIDE PLANS.

11 NEW SECTION. Section 7. Cost containment. (1) The
 12 statewide plans must contain a cost containment component,
 13 INCLUDING ANNUAL COST CONTAINMENT TARGETS. Except as
 14 otherwise provided in this section, each statewide plan must
 15 establish ~~a--target~~ TARGETS for cost containment so that by
 16 1999, the annual average percentage increase in statewide
 17 health care costs does not exceed the average annual
 18 percentage increase in the gross domestic product, as
 19 determined by the U.S. department of commerce, for the 5
 20 preceding years.

21 (2) The authority shall adopt processes and criteria
 22 for responding to exceptional and unforeseen circumstances
 23 that affect the health care system and the target TARGETS
 24 required in subsection (1), including such factors as
 25 population increases or decreases, demographic changes,

1 costs beyond the control of health care providers, and other
2 factors that the authority considers significant.

3 (3) The authority shall, AT A MINIMUM, include the
4 following features in the cost containment component:

5 (a) global budgeting for all health care spending;

6 (b) a system for limiting demand of health care
7 services and controlling unnecessary and inappropriate
8 health care. The system may include prioritization of
9 services that allows for consideration of an individual
10 patient's prognosis ~~AND-AN-INDIVIDUAL'S-CHOICE-OF-SERVICES~~.

11 (c) a system for reimbursing health care providers for
12 services and health care items. The reimbursement system
13 must provide that all payors, public or private, pay the
14 same rate for the same health care services and items and
15 that reimbursement for services is based predominantly upon
16 the health care service provided rather than upon the
17 discipline of the health care provider.

18 (d) a method of monitoring compliance with the target
19 TARGETS required in subsection (1);

20 (e) expenditure targets for health care providers and
21 facilities;

22 (f) disincentives for exceeding the targets established
23 pursuant to subsection (3)(e), including reduction of
24 reimbursement levels in subsequent years;

25 (g) reimbursement of health care providers and health

1 care facilities that is based upon negotiated annual budgets
2 or fees for services; and

3 (h) a plan by the authority, health care providers,
4 health insurers, and health care facilities to educate the
5 public concerning the purpose and content of the statewide
6 plans.

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

15 (2) The management plan must include:

16 (a) a statement of principles used in the allocation of
17 resources and in establishing priorities for health
18 services;

19 (b) identification of the current supply and
20 distribution of:

21 (i) hospital, nursing home, and other inpatient
22 services;

23 (ii) home health and mental health services;

24 (iii) treatment services for alcohol and drug abuse;

25 (iv) emergency care;

(v) ambulatory care services, including primary care resources;

(vi) nutrition benefits, prenatal benefits, and maternity care;

(vii) human resources;

(VIII) HEALTH SCIENCES LIBRARY RESOURCES AND SERVICES;

~~(viii)~~ (IX) major medical equipment; and

~~(ix)~~ (X) health screening and early intervention services;

(c) a determination of the appropriate supply and distribution of the resources and services identified in subsection (2)(b) and of the mechanisms that will encourage the appropriate integration of these services on a local or regional basis. To arrive at a determination, the authority shall consider the following factors:

(i) the needs of the statewide population, with special consideration given to the development of health care services in underserved areas of the state;

(ii) the needs of particular geographic areas of the state;

(iii) the use of Montana facilities by out-of-state residents;

(iv) the use of out-of-state facilities by Montana residents;

(v) the needs of populations with special health care

needs;

(vi) the desirability of providing high-quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; and

(vii) the cost impact of these resource requirements on health care expenditures;

(d) a component that addresses health promotion and disease prevention and that is prepared by the department of health and environmental sciences in a format established by the authority;

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

(f) incentives for healthy lifestyles;

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

(i) a system by which the authority may identify persons with an interest in becoming health care professionals and provide or assist in providing health care education for those persons; and

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

(h) a component that addresses integration of the plan, to the extent allowed by state and federal law, with

services provided by the Indian health service and by the United States department of veterans affairs and by the medicare and medicaid programs.

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

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

(5) Prior to adoption of the management plan, the authority shall hold one or more public hearings for the purpose of receiving oral and written comment on a draft plan. After hearings have been concluded, the authority shall adopt the management plan, taking comments into consideration.

NEW SECTION. Section 9. Health care billing simplification. (1) Each statewide plan must contain a component providing for simplification and reduction of the costs associated with health care billing. In designing this component, the authority may consider:

(a) conversion from paper health care claims to standardized electronic billing; and

(b) creating a claims clearinghouse, consisting of a state agency or private entity, to receive claims from all health care providers for compiling, editing, and submitting the claims to payors.

(2) The health care billing component must include a method to educate and assist health care providers and payors who will use any health care billing simplification system recommended by the authority.

(3) The billing component must provide a schedule for a phase in of any health care billing simplification system recommended by the authority. The schedule must relieve health care providers, payors, and consumers of undue burdens in using the system.

NEW SECTION. Section 10. Uniform claim forms and procedures. (1) ~~By January 17, 1994, the~~ THE commissioner of insurance, after consultation with the authority, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system.

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

NEW SECTION. Section 11. Other matters to be included in statewide plans. (1) The statewide plans recommended by the authority must include:

(a) stable financing methods, including sharing of the costs of health care by health care consumers on an ability-to-pay basis through such mechanisms as copayments or payment of premiums;

(b) a procedure for evaluating the quality of health care services;

(c) public education concerning the statewide plans recommended by the authority; and

(d) phasein of the various components of the plans.

(2) (a) In order to reduce the costs of defensive medicine, the authority shall:

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

(ii) conduct a study of tort reform measures, including limitations on the amount of noneconomic damages, mandated periodic payments of future damages, and reverse sliding scale limits on contingency fees; and

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

(b) As part of its study under subsection (2)(a)(ii), the authority may consider changes in the Montana Medical Legal Panel Act.

(c) The recommendations of the authority must be

included in its report containing the statewide plans.

(3) The authority shall conduct a study of the impacts of federal and state antitrust laws on health care services in the state and make recommendations, including legislation, to address those laws and impacts. The authority ~~shall~~ MAY include in its plans legislation IN ADDITION TO [SECTIONS 37 THROUGH 44] that will enable health care providers and payors, including health insurers and consumers, to negotiate and enter into agreements when the agreements are likely to result in lower costs or in greater access or quality than would otherwise occur in the competitive marketplace. In proposing appropriate legislation concerning antitrust laws, the authority shall provide appropriate conditions, supervision, and regulation to protect against private abuse of economic power.

(4) The authority shall apply for waivers from federal laws necessary to implement recommendations of the authority enacted by the legislature and to implement those recommendations not requiring legislation.

NEW SECTION. Section 12. Hearings. AVAILABILITY OF PLANS -- HEARINGS on statewide plans. (1) THE AUTHORITY SHALL MAKE COPIES OF THE DRAFT STATEWIDE PLANS WIDELY AVAILABLE AT PUBLIC EXPENSE TO INTERESTED PERSONS AND GROUPS.

(2) The authority shall seek public comment on the

1 development of each statewide plan required under [section
2 5]. In seeking public comment on the development of the
3 authority's recommendations for each plan, the authority
4 shall provide extensive, multimedia notice to the public and
5 hold at least one public hearing in each of the health care
6 planning regions established by [section 17]. The hearings
7 must take place before the authority's report is submitted
8 to the legislature. The authority shall consult with health
9 care providers in the development of its recommendations for
10 each statewide plan.

11 (3) THE AUTHORITY SHALL CONSIDER ORAL AND WRITTEN
12 PUBLIC COMMENTS ON THE STATEWIDE PLANS BEFORE RECOMMENDING
13 THEM TO THE LEGISLATURE.

14 NEW SECTION. Section 13. State purchasing pool --
15 reports required. (1) On or before December 15, 1994, and
16 December 15, 1996, the authority shall report to the
17 legislature on establishment of a state purchasing pool,
18 including the number and types of groups and group members
19 participating in the pool, the costs of administering the
20 pool, the savings attributable to participating groups from
21 the operation of the pool, and any changes in legislation
22 considered necessary by the authority.

23 (2) On or before December 15, 1996, the authority shall
24 report to the legislature its recommendations concerning the
25 feasibility and merits of authorizing the authority to act

1 as an insurer in pooling risks and providing benefits,
2 including a common benefits plan, to participants of the
3 purchasing pool.

4 NEW SECTION. Section 14. Study of prescription drug
5 cost and distribution. The authority shall conduct a study
6 of the cost and distribution of prescription drugs in this
7 state. The study must consider the feasibility of various
8 methods of reducing the cost of purchasing and distributing
9 prescription drugs to Montana residents. The study must
10 include the feasibility of establishing a prescription drug
11 purchasing pool for distribution of drugs through
12 pharmacists in this state. The results of the study,
13 including the authority's recommendations for any necessary
14 legislation, must be reported to the legislature by December
15 1, 1996. If the authority determines that feasible methods
16 are available without need for legislation or
17 appropriations, the authority shall implement that part or
18 those parts of its recommendations.

19 NEW SECTION. Section 15. Long-term care study and
20 recommendations. (1) The authority shall conduct a study of
21 the long-term care needs of state residents and report to
22 the public and the legislature the authority's
23 recommendations, including any necessary legislation, for
24 meeting those long-term care needs. The report must be
25 available to the public on or before September 1, 1996,

after which the authority shall conduct public hearings on its report in each region established under [section 17]. The authority shall present its report to the legislature on or before January 1, 1997.

(2) This section does not preclude the authority from recommending cost-sharing arrangements for long-term care services or from recommending that the services be phased in over time. The authority's recommendations must support and may not supplant informal care giving by family and friends and must include cost containment recommendations for any long-term care service suggested for inclusion.

(3) The authority's report must estimate costs associated with each of the long-term care services recommended and may suggest independent financing mechanisms for those services. The report must also set forth the projected cost to Montana and its citizens over the next 20 years if there is no change in the present accessibility, affordability, or financing of long-term care services in this state.

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

NEW SECTION. Section 16. Study of certificate of need process. (1) The authority shall conduct a study of the certificate of need process established under Title 50,

chapter 5, part 3. The study must determine whether changes in the certificate of need process are necessary or desirable in light of the authority's recommendation for a single payor health care system required by [section 5]. The study must include consideration of the role, effect, and desirability of:

(a) maintaining the exemptions from the certificate of need process for HOSPITALS AND FOR offices of private physicians, dentists, and other physical and mental health care professionals; and

(b) maintaining the dollar thresholds for health care services, equipment, and buildings and for construction of health care facilities.

(2) The results of the study, including any recommendations for legislation and changes in an agency's policies or rules, must be reported to the legislature no later than December 1, 1994.

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

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

1 Carter;

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

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

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

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

12 (2) (a) A county may, by written request of the board
13 of county commissioners, petition the authority at any time
14 to be removed from a health care planning region and added
15 to another region.

16 (b) The authority shall grant or deny the petition
17 after a public hearing. The authority shall give notice as
18 the authority determines appropriate. The authority shall
19 grant the petition if it appears by a preponderance of the
20 evidence that the petitioning county's health care interests
21 are more strongly associated with the region that the county
22 seeks to join than with the region in which the county is
23 located. If the authority grants the petition, the county is
24 considered for all purposes to be part of the health care
25 planning region as approved by the authority.

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

9 (4) The authority shall, within 30 days of appointment
10 of its members, propose by rule a procedure for selecting
11 members of boards. The authority shall select the members
12 for each board within 180 days of appointment of the
13 authority, using the selection procedure adopted by rule
14 under this subsection. Vacancies on a board must be filled
15 by using the authority's selection process.

16 (5) Regional board members serve 4-year terms, except
17 that of the board members initially selected, at least three
18 members serve for 2 years, at least three members serve for
19 3 years, and at least three members serve for 4 years, to be
20 determined by lot. A majority of each regional board shall
21 select a presiding officer. The presiding officer initially
22 selected must serve a 4-year term. Board members must be
23 compensated and reimbursed in accordance with 2-15-124.

24 NEW SECTION. **Section 18. Powers and duties of boards.**

25 (1) A board shall:

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

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

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

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

14 (e) revise the regional plan annually;

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

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

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

24 (i) seek from ~~local~~ PUBLIC AND PRIVATE sources money to
 25 supplement grant funds provided by the authority.

1 (2) Regional boards may:

2 (a) recommend that the authority sanction voluntary
 3 agreements between health care providers and between health
 4 care consumers in the region that will improve the quality
 5 of, access to, or affordability of health care but that
 6 might constitute a violation of antitrust laws if undertaken
 7 without government direction;

8 (b) make recommendations to the authority regarding
 9 major capital expenditures or the introduction of expensive
 10 new technologies and medical practices that are being
 11 proposed or considered by health care providers;

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

16 (d) make recommendations to the department of health
 17 and environmental sciences or to the authority, or both,
 18 regarding ways of improving affordability, accessibility,
 19 and quality of health care in the region and throughout the
 20 state.

21 (3) Each regional board may review and advise the
 22 authority on regional technical matters relating to the
 23 statewide plans required by [section 5], the common benefits
 24 package, procedures for developing and applying practice
 25 guidelines for use in the statewide plans, provider and

1 facility contracts with the state, utilization review
2 recommendations, expenditure targets, and uniform health
3 care benefits and the impact of the benefits upon the
4 provision of quality health care within the region.

5 NEW SECTION. **Section 19.** Health care data base --
6 information submitted -- enforcement. (1) The authority
7 shall develop and maintain a unified health care data base
8 that enables the authority, on a statewide basis, to:

9 (a) determine the distribution and capacity of health
10 care resources, including health care facilities, providers,
11 and health care services;

12 (b) identify health care needs and direct statewide and
13 regional health care policy to ensure high-quality and
14 cost-effective health care;

15 (c) conduct evaluations of health care procedures and
16 health care protocols;

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

21 (e) compare costs of various health care procedures in
22 one location of providers and health care facilities with
23 the costs of the same procedures in other locations of
24 providers and health care facilities.

25 (2) The authority shall by rule require health care

1 providers, health insurers, health care facilities, private
2 entities, and entities of state and local governments to
3 file with the authority the reports, data, schedules,
4 statistics, and other information determined by the
5 authority to be necessary to fulfill the purposes of the
6 data base provided in subsection (1). Material to be filed
7 with the authority may include health insurance claims and
8 enrollment information used by health insurers.

9 (3) The authority may issue subpoenas for the
10 production of information required under this section and
11 may issue subpoenas for and administer oaths to any person.
12 Noncompliance with a subpoena issued by the authority is,
13 upon application by the authority, punishable by a district
14 court as contempt pursuant to Title 3, chapter 1, part 5.

15 (4) The data base must:

16 (a) use unique patient and provider identifiers and a
17 uniform coding system identifying health care services; and

18 (b) reflect all health care utilization, costs, and
19 resources in the state and the health care utilization and
20 costs of services provided to Montana residents in another
21 state.

22 (5) Information in the data base required by law to be
23 kept confidential must be maintained in a manner that does
24 not disclose the identity of the person to whom the
25 information applies. INFORMATION IN THE DATA BASE NOT

REQUIRED BY LAW TO BE KEPT CONFIDENTIAL MUST BE MADE
AVAILABLE BY THE AUTHORITY UPON REQUEST OF ANY PERSON.

(6) The authority shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

NEW SECTION. Section 20. Health insurer cost management plans. (1) (a) Except as provided in subsection (3), each health insurer shall:

(i) prepare a cost management plan that includes integrated systems for health care delivery; and

(ii) file the plan with the authority no later than January 1, 1994.

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

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

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

Section 21. Section 50-1-201, MCA, is amended to read:

"50-1-201. Administration of state health plan. The department Montana health care authority created in [section 3] is hereby-established-as the sole--and--official state agency to administer the state program for comprehensive

health planning and ~~is hereby authorized to~~ shall prepare a plan for comprehensive state health planning. The department ~~authority is authorized to~~ may confer and cooperate with any ~~and--all~~ other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The department authority, while acting in this capacity as the ~~sole-and-official~~ state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the ~~sole-and-official~~ state agency to accept, receive, expend, and administer ~~any-and-all~~ funds which--are now--available-or-which-may-be donated, granted, bequeathed, or appropriated to it for the preparation, and administration, and the supervision of the preparation and administration of the comprehensive state health plan."

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

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

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

(b) to prevent abusive rating practices;

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

(d) to establish rules regarding renewability of coverage;

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

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

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

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

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

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

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

in establishing premium rates for applicable health benefit plans.

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

(3) "ASSESSABLE CARRIER" MEANS ALL INDIVIDUAL CARRIERS OF DISABILITY INSURANCE AND ALL CARRIERS OF GROUP DISABILITY INSURANCE, EXCLUDING THE STATE GROUP BENEFITS PLAN PROVIDED FOR IN TITLE 2, CHAPTER 18, PART 8, THE MONTANA UNIVERSITY SYSTEM HEALTH PLAN, AND ANY SELF-FUNDED DISABILITY INSURANCE PLAN PROVIDED BY A POLITICAL SUBDIVISION OF THE STATE.

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

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

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

(7) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an

insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For purposes of [sections 22 through 36], companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

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

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

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

~~f7~~(8) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claims experience, health status, and duration of coverage are not case characteristics for purposes of [sections 22 through 36].

~~f8~~(9) "Class of business" means all or a separate grouping of small employers established pursuant to [section 26].

~~f9~~(10) "Committee" means the health benefit plan committee created pursuant to [section 31].

~~f10~~(11) "Dependent" means:

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

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

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

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

~~f11~~(12) "Eligible employee" means an employee who works on a full-time basis and who has a normal workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

~~f12~~(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based

on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

{13}(14) "Health benefit plan" means any hospital or medical policy or certificate PROVIDING FOR PHYSICAL AND MENTAL HEALTH CARE issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

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

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

(c) automobile medical payment insurance.

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

{15}(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial

enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

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

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

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

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

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

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

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

1 with similar case characteristics for newly issued health
2 benefit plans with the same or similar coverage.

3 {17}(18) "Plan of operation" means the operation of the
4 program established pursuant to [section 30].

5 {18}(19) "Premium" means all money paid by a small
6 employer and eligible employees as a condition of receiving
7 coverage from a small employer carrier, including any fees
8 or other contributions associated with the health benefit
9 plan.

10 {19}(20) "Program" means the Montana small employer
11 health reinsurance program created by [section 30].

12 {20}(21) "Qualifying previous coverage" means benefits
13 or coverage provided under:

14 (a) medicare or medicaid;

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

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

1 {21}(22) "Rating period" means the calendar period for
2 which premium rates established by a small employer carrier
3 are assumed to be in effect.

4 {22}(23) "Reinsuring carrier" means a small employer
5 carrier participating in the reinsurance program pursuant to
6 [section 30].

7 {23}(24) "Restricted network provision" means a
8 provision of a health benefit plan that conditions the
9 payment of benefits, in whole or in part, on the use of
10 health care providers that have entered into a contractual
11 arrangement with the carrier pursuant to Title 33, chapter
12 22, part 17, or Title 33, chapter 31, to provide health care
13 services to covered individuals.

14 {24}(25) "Small employer" means a person, firm,
15 corporation, partnership, or association that is actively
16 engaged in business and that, on at least 50% of its working
17 days during the preceding calendar quarter, employed at
18 least 3 but not more than 25 eligible employees, the
19 majority of whom were employed within this state or were
20 residents of this state. In determining the number of
21 eligible employees, companies that ARE CONSIDERED ONE
22 EMPLOYER IF THEY:

23 (A) are affiliated companies ~~or that~~;

24 (B) are eligible to file a combined tax return for
25 purposes of state taxation; OR

(C) ~~THAT ARE MEMBERS OF AN ASSOCIATION THAT:~~

(I) ~~HAS BEEN IN EXISTENCE FOR 1 YEAR PRIOR TO [THE EFFECTIVE DATE OF SECTIONS 22 THROUGH 36];~~

(II) ~~AND---THAT PROVIDES A HEALTH BENEFIT PLAN TO EMPLOYEES OF ITS MEMBERS AS A GROUP are--considered--one employer; AND~~

(III) ~~DOES NOT DENY COVERAGE TO ANY MEMBER OF ITS ASSOCIATION OR ANY EMPLOYEE OF ITS MEMBERS WHO APPLIES FOR COVERAGE AS PART OF A GROUP.~~

{25}{26} "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

{26}{27} "Standard health benefit plan" means a health benefit plan developed pursuant to [section 31].

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

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

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

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

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

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

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

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

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

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

(4) The commissioner may approve the establishment of

1 additional classes of business upon application to the
2 commissioner and a finding by the commissioner that the
3 action would enhance the fairness and efficiency of the
4 small employer health insurance market.

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

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

12 (b) For each class of business:

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

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

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

4 (i) the percentage change in the new business premium
5 rate measured from the first day of the prior rating period
6 to the first day of the new rating period; ~~in~~ IN the case
7 of a health benefit plan into which the small employer
8 carrier is no longer enrolling new small employers, the
9 small employer carrier shall use the percentage change in
10 the base premium rate, provided that the change does not
11 exceed, on a percentage basis, the change in the new
12 business premium rate for the most similar health benefit
13 plan into which the small employer carrier is actively
14 enrolling new small employers; i

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

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

25 (d) Adjustments in rates for claims experience, health

status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

~~{e}--Premium rates for health benefit plans must comply with the requirements of this section, notwithstanding any assessments paid or payable by small employer carriers pursuant to {section 30}.~~

~~{f}{(E)}~~ If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage.

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

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; ~~in;~~ IN the case of a health benefit plan into which the small employer

carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; AND

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

~~{h}{(G)}~~ A small employer carrier shall:

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

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

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

1 ~~{j}--The--small--employer--carrier--may--not--use--case~~
 2 ~~characteristics,--other--than--age,--without--prior--approval--of~~
 3 ~~the--commissioner.~~

4 {k}{I} The commissioner may SHALL adopt rules to
 5 implement the provisions of this section and to ensure that
 6 rating practices used by small employer carriers are
 7 consistent with the purposes of [sections 22 through 36],
 8 including rules that ensure that differences in rates
 9 charged for health benefit plans by small employer carriers
 10 are reasonable and reflect objective differences in plan
 11 design, not including differences because of the nature of
 12 the groups.

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

21 (3) The commissioner may suspend for a specified period
 22 the application of subsection (1)(a) for the premium rates
 23 applicable to one or more small employers included within a
 24 class of business of a small employer carrier for one or
 25 more rating periods upon a filing by the small employer

1 carrier and a finding by the commissioner either that the
 2 suspension is reasonable in light of the financial condition
 3 of the small employer carrier or that the suspension would
 4 enhance the fairness and efficiency of the small employer
 5 health insurance market.

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

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

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

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

21 (d) the provisions relating to any preexisting
 22 condition.

23 (5) (a) Each small employer carrier shall maintain at
 24 its principal place of business a complete and detailed
 25 description of its rating practices and renewal underwriting

practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

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

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

NEW SECTION. Section 28. Renewability of coverage. (1)

A health benefit plan subject to the provisions of [sections 22 through 36] is renewable with respect to all eligible

employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

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

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

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

(e) repeated misuse of a restricted network provision;

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

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

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

1 affected small employers.

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

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

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

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

11 (3) A small employer carrier that elects not to renew a
12 health benefit plan under subsection (1)(f) is prohibited
13 from writing new business in the small employer market in
14 this state for a period of 5 years from the date of notice
15 to the commissioner.

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

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

1 plan.

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

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

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

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

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

25 (D) the small employer carrier provides for the

1 acceptance of all eligible small employers into one or more
2 classes of business.

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

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

13 (2) (a) A small employer carrier shall, pursuant to
14 33-1-501, file the basic health benefit plans and the
15 standard health benefit plans to be used by the small
16 employer carrier.

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

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

25 (a) A health benefit plan may not, because of a

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

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

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

25 (d) (i) Requirements used by a small employer carrier

1 in determining whether to provide coverage to a small
 2 employer, including requirements for minimum participation
 3 of eligible employees and minimum employer contributions,
 4 must be applied uniformly among all small employers that
 5 have the same number of eligible employees and that apply
 6 for coverage or receive coverage from the small employer
 7 carrier.

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

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

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

25 (4) (a) A small employer carrier may not be required to

1 offer coverage or accept applications pursuant to subsection
 2 (1) in the case of the following:

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

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

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

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

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

1 health reinsurance program.

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

8 (b) (i) In selecting the members of the board, the
9 commissioner shall include representatives of small
10 employers, small employer carriers, and other qualified
11 individuals, as determined by the commissioner. At least six
12 of the members of the board must be representatives of small
13 employer carriers, one from each of the five small employer
14 carriers with the highest annual premium volume derived from
15 health benefit plans issued to small employers in Montana in
16 the previous calendar year and one from the remaining small
17 employer carriers. One member of the board must be a person
18 licensed, certified, or otherwise authorized by the laws of
19 Montana to provide health care in the ordinary course of
20 business or in the practice of a profession. One member of
21 the board must be a small employer who is not active in the
22 health care or insurance fields. One member of the board
23 must be a representative of the general public who is
24 employed by a small employer and is not employed in the
25 health care or insurance fields.

1 (ii) The initial board members' terms are as follows:

2 one-third of the members shall serve a term of 1 year;
3 one-third of the members shall serve a term of 2 years; and
4 one-third of the members shall serve a term of 3 years.
5 Subsequent board members shall serve for a term of 3 years.
6 A board member's term continues until that member's
7 successor is appointed.

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

11 (3) Within [60 days of the effective date of this
12 section] AND ON OR BEFORE MARCH 1 OF EACH YEAR AFTER THAT
13 DATE, each ~~small-employer~~ ASSESSABLE carrier shall file with
14 the commissioner the carrier's net health insurance premium
15 derived from health benefit plans issued ~~to-small-employers~~
16 in this state in the previous calendar year.

17 (4) Within 180 days after the appointment of the
18 initial board, the board shall submit to the commissioner a
19 plan of operation and may at any time submit amendments to
20 the plan necessary or suitable to ensure the fair,
21 reasonable, and equitable administration of the program. The
22 commissioner may, after notice and hearing, approve the plan
23 of operation if the commissioner determines it to be
24 suitable to ensure the fair, reasonable, and equitable
25 administration of the program and if the plan of operation

1 provides for the sharing of program gains or losses on an
2 equitable and proportionate basis in accordance with the
3 provisions of this section. The plan of operation is
4 effective upon written approval by the commissioner.

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

12 (6) The plan of operation must:

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

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

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

21 (d) establish procedures for collecting assessments
22 from reinsuring ASSESSABLE carriers to fund claims and
23 ~~administrative-expenses incurred or-estimated-to-be-incurred~~
24 by the program; and

25 (E) ESTABLISH PROCEDURES FOR ALLOCATING A PORTION OF

1 PREMIUMS COLLECTED FROM REINSURING CARRIERS TO FUND
2 ADMINISTRATIVE EXPENSES INCURRED OR TO BE INCURRED BY THE
3 PROGRAM; AND

4 ~~te)(F)~~ provide for any additional matters necessary for
5 the implementation and administration of the program.

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

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

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

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

25 (d) define the health benefit plans for which

1 reinsurance will be provided and to issue reinsurance
2 policies in accordance with the requirements of [sections 22
3 through 36];

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

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

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

13 (H) TO THE EXTENT PERMITTED BY FEDERAL LAW AND IN
14 ACCORDANCE WITH SUBSECTION (11)(C), MAKE ANNUAL FISCAL
15 YEAREND ASSESSMENTS AGAINST ASSESSABLE CARRIERS AND MAKE
16 INTERIM ASSESSMENTS TO FUND CLAIMS INCURRED BY THE PROGRAM;
17 AND

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

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

24 (a) With respect to a basic health benefit plan or a
25 standard health benefit plan, the program shall reinsure the

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

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

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

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

24 (ii) The board annually shall adjust the initial level
25 of claims and maximum limit to be retained by the carrier to

1 reflect increases in costs and utilization within the
 2 standard market for health benefit plans within the state.
 3 The adjustment may not be less than the annual change in the
 4 medical component of the consumer price index for all urban
 5 consumers of the United States department of labor, bureau
 6 of labor statistics, unless the board proposes and the
 7 commissioner approves a lower adjustment factor.

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

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

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

23 (9) (a) As part of the plan of operation, the board
 24 shall establish a methodology for determining premium rates
 25 to be charged by the program for reinsuring small employers

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

16 (b) Premiums for the program are as follows:

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

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

25 (c) The board periodically shall review the methodology

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

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

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

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

20 (b) ~~A-net-loss-for-the-year-must-be-reimbursed-by-the~~
 21 ~~commissioner--from--funds-specifically-appropriated-for-that~~
 22 ~~purpose.~~ TO THE EXTENT PERMITTED BY FEDERAL LAW, EACH
 23 ASSESSABLE CARRIER SHALL SHARE IN ANY NET LOSS OF THE
 24 PROGRAM FOR THE YEAR IN AN AMOUNT EQUAL TO THE RATIO OF THE
 25 TOTAL PREMIUMS EARNED IN THE PREVIOUS CALENDAR YEAR FROM

1 HEALTH BENEFIT PLANS DELIVERED OR ISSUED FOR DELIVERY BY
 2 EACH ASSESSABLE CARRIER DIVIDED BY THE TOTAL PREMIUMS EARNED
 3 IN THE PREVIOUS CALENDAR YEAR FROM HEALTH BENEFIT PLANS
 4 DELIVERED OR ISSUED FOR DELIVERY BY ALL ASSESSABLE CARRIERS
 5 IN THE STATE.

6 (C) THE BOARD SHALL MAKE AN ANNUAL DETERMINATION IN
 7 ACCORDANCE WITH THIS SECTION OF EACH ASSESSABLE CARRIER'S
 8 LIABILITY FOR ITS SHARE OF THE NET LOSS OF THE PROGRAM AND,
 9 EXCEPT AS OTHERWISE PROVIDED BY THIS SECTION, MAKE AN ANNUAL
 10 FISCAL YEAREND ASSESSMENT AGAINST EACH ASSESSABLE CARRIER TO
 11 THE EXTENT OF THAT LIABILITY. IF APPROVED BY THE
 12 COMMISSIONER, THE BOARD MAY ALSO MAKE INTERIM ASSESSMENTS
 13 AGAINST ASSESSABLE CARRIERS TO FUND CLAIMS INCURRED BY THE
 14 PROGRAM. ANY INTERIM ASSESSMENT MUST BE CREDITED AGAINST THE
 15 AMOUNT OF ANY FISCAL YEAREND ASSESSMENT DUE OR TO BE DUE
 16 FROM AN ASSESSABLE CARRIER. PAYMENT OF A FISCAL YEAREND OR
 17 INTERIM ASSESSMENT IS DUE WITHIN 30 DAYS OF RECEIPT BY THE
 18 ASSESSABLE CARRIER OF WRITTEN NOTICE OF THE ASSESSMENT. AN
 19 ASSESSABLE CARRIER THAT CEASES DOING BUSINESS WITHIN THE
 20 STATE IS LIABLE FOR ASSESSMENTS UNTIL THE END OF THE
 21 CALENDAR YEAR IN WHICH THE ASSESSABLE CARRIER CEASED DOING
 22 BUSINESS. THE BOARD MAY DETERMINE NOT TO ASSESS AN
 23 ASSESSABLE CARRIER IF THE ASSESSABLE CARRIER'S LIABILITY
 24 DETERMINED IN ACCORDANCE WITH THIS SECTION DOES NOT EXCEED
 25 \$10.

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

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

(14) The program is exempt from taxation.

(15) ON OR BEFORE MARCH 1 OF EACH YEAR, THE COMMISSIONER SHALL EVALUATE THE OPERATION OF THE PROGRAM AND REPORT TO THE GOVERNOR AND THE LEGISLATURE IN WRITING THE RESULTS OF THE EVALUATION. THE REPORT MUST INCLUDE AN ESTIMATE OF FUTURE COSTS OF THE PROGRAM, ASSESSMENTS NECESSARY TO PAY THOSE COSTS, THE APPROPRIATENESS OF PREMIUMS CHARGED BY THE

PROGRAM, THE LEVEL OF INSURANCE RETENTION UNDER THE PROGRAM, THE COST OF COVERAGE OF SMALL EMPLOYERS, AND ANY RECOMMENDATIONS FOR CHANGE TO THE PLAN OF OPERATION.

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

(A) ONE HEALTH CARE PROVIDER;

(B) ONE REPRESENTATIVE OF THE HEALTH INSURANCE INDUSTRY;

(C) ONE EMPLOYEE OF A SMALL EMPLOYER;

(D) ONE MEMBER OF A LABOR UNION; AND

(E) ONE REPRESENTATIVE OF THE GENERAL PUBLIC WHO MAY NOT REPRESENT THE PERSONS OR GROUPS LISTED IN SUBSECTIONS (1)(A) THROUGH (1)(D).

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

(3) (a) The committee shall recommend benefit levels, cost-sharing levels, exclusions, and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall design a basic health benefit plan and a standard health benefit plan that contain benefit and cost-sharing levels that are consistent with the basic

1 method of operation and the benefit plans of health
2 maintenance organizations, including any restrictions
3 imposed by federal law.

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

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

9 (ii) case management;

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

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

15 (v) other managed care provisions.

16 (c) The committee shall submit the health benefit plans
17 described in subsections (3)(a) and (3)(b) to the
18 commissioner for---approval within 180 days after the
19 appointment of the committee. THE COMMISSIONER SHALL ADOPT
20 AS A RULE PURSUANT TO TITLE 2, CHAPTER 4, PART 3, THE HEALTH
21 BENEFIT PLANS REQUIRED BY [SECTION 29(1)] TO BE OFFERED IN
22 THIS STATE.

23 NEW SECTION. Section 32. Periodic market evaluation --
24 report. The board, in consultation with members of the
25 committee, shall study and report at least every 3 years to

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

13 NEW SECTION. Section 33. Waiver of certain laws. A law
14 that requires the inclusion of a specific category of
15 licensed health care practitioner--does PRACTITIONERS AND A
16 LAW THAT REQUIRES THE COVERAGE OF A HEALTH CARE SERVICE OR
17 BENEFIT DO not apply to a basic health benefit plan
18 delivered or issued for delivery to small employers in this
19 state pursuant to [sections 22 through 36] BUT DO APPLY TO A
20 STANDARD HEALTH BENEFIT PLAN DELIVERED OR ISSUED FOR
21 DELIVERY TO SMALL EMPLOYERS IN THIS STATE PURSUANT TO
22 [SECTIONS 22 THROUGH 36].

23 NEW SECTION. Section 34. Administrative procedure. The
24 commissioner shall adopt rules in accordance with the
25 Montana Administrative Procedure Act to implement and

1 administer [sections 22 through 36].

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

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

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

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

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

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

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

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

25 (5) A small employer carrier may not terminate, fail to

1 renew, or limit its contract or agreement of representation
 2 with a producer for any reason related to the health status
 3 of the employer's employees or the claims experience,
 4 industry, occupation, or geographic location of the small
 5 employers placed by the producer with the small employer
 6 carrier.

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

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

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

19 (9) (a) A violation of this section by a small employer
 20 carrier or a producer is an unfair trade practice under
 21 33-18-102.

22 (b) If a small employer carrier enters into a contract,
 23 agreement, or other arrangement with an administrator who
 24 holds a certificate of registration pursuant to 33-17-603 to
 25 provide administrative, marketing, or other services related

1 to the offering of health benefit plans to small employers
 2 in this state, the administrator is subject to this section
 3 as if the administrator were a small employer carrier.

4 NEW SECTION. Section 36. Restoration of terminated
 5 coverage. The commissioner may promulgate rules to require
 6 small employer carriers, as a condition of transacting
 7 business with small employers in this state after [the
 8 effective date of this section], to reissue a health benefit
 9 plan to any small employer whose health benefit plan has
 10 been terminated or not renewed by the carrier after [6
 11 months prior to the effective date of this section]. The
 12 commissioner may prescribe the terms for the reissuance of
 13 coverage that the commissioner finds are reasonable and
 14 necessary to provide continuity of coverage to small
 15 employers.

16 NEW SECTION. SECTION 37. FINDING AND PURPOSE. THE
 17 LEGISLATURE FINDS THAT THE GOALS OF CONTROLLING HEALTH CARE
 18 COSTS AND IMPROVING THE QUALITY OF AND ACCESS TO HEALTH CARE
 19 WILL BE SIGNIFICANTLY ENHANCED IN SOME CASES BY COOPERATIVE
 20 AGREEMENTS AMONG HEALTH CARE FACILITIES. THE PURPOSE OF
 21 [SECTIONS 37 THROUGH 44] IS TO PROVIDE THE STATE, THROUGH
 22 THE AUTHORITY, WITH DIRECT SUPERVISION AND CONTROL OVER THE
 23 IMPLEMENTATION OF COOPERATIVE AGREEMENTS AMONG HEALTH CARE
 24 FACILITIES FOR WHICH CERTIFICATES OF PUBLIC ADVANTAGE ARE
 25 GRANTED. IT IS THE INTENT OF THE LEGISLATURE THAT

SUPERVISION AND CONTROL OVER THE IMPLEMENTATION OF THESE AGREEMENTS SUBSTITUTE STATE REGULATION OF FACILITIES FOR COMPETITION BETWEEN FACILITIES AND THAT THIS REGULATION HAVE THE EFFECT OF GRANTING THE PARTIES TO THE AGREEMENTS STATE ACTION IMMUNITY FOR ACTIONS THAT MIGHT OTHERWISE BE CONSIDERED TO BE IN VIOLATION OF STATE OR FEDERAL, OR BOTH, ANTITRUST LAWS.

NEW SECTION. SECTION 38. COOPERATIVE AGREEMENTS ALLOWED. A HEALTH CARE FACILITY MAY ENTER INTO A COOPERATIVE AGREEMENT WITH ONE OR MORE HEALTH CARE FACILITIES.

NEW SECTION. SECTION 39. CERTIFICATE OF PUBLIC ADVANTAGE -- STANDARDS FOR CERTIFICATION -- TIME FOR ACTION BY AUTHORITY. (1) PARTIES TO A COOPERATIVE AGREEMENT MAY APPLY TO THE AUTHORITY FOR A CERTIFICATE OF PUBLIC ADVANTAGE. THE APPLICATION FOR A CERTIFICATE MUST INCLUDE A COPY OF THE PROPOSED OR EXECUTED AGREEMENT, A DESCRIPTION OF THE SCOPE OF THE COOPERATION CONTEMPLATED BY THE AGREEMENT, AND THE AMOUNT, NATURE, SOURCE, AND RECIPIENT OF ANY CONSIDERATION PASSING TO ANY PERSON UNDER THE TERMS OF THE AGREEMENT.

(2) THE AUTHORITY SHALL HOLD A PUBLIC HEARING ON THE APPLICATION FOR A CERTIFICATE BEFORE ACTING UPON THE APPLICATION. THE AUTHORITY MAY NOT ISSUE A CERTIFICATE UNLESS THE AUTHORITY FINDS THAT THE AGREEMENT IS LIKELY TO RESULT IN LOWER HEALTH CARE COSTS OR IN GREATER ACCESS TO OR

QUALITY OF HEALTH CARE THAN WOULD OCCUR WITHOUT THE AGREEMENT. IF THE AUTHORITY DENIES AN APPLICATION FOR A CERTIFICATE FOR AN EXECUTED AGREEMENT, THE AGREEMENT IS VOID UPON THE DECISION OF THE AUTHORITY NOT TO ISSUE THE CERTIFICATE. PARTIES TO A VOID AGREEMENT MAY NOT IMPLEMENT OR CARRY OUT THE AGREEMENT.

(3) THE AUTHORITY SHALL DENY THE APPLICATION FOR A CERTIFICATE OR ISSUE A CERTIFICATE WITHIN 90 DAYS OF RECEIPT OF A COMPLETED APPLICATION.

NEW SECTION. SECTION 40. RECONSIDERATION BY AUTHORITY.

(1) IF THE AUTHORITY DENIES AN APPLICATION AND REFUSES TO ISSUE A CERTIFICATE, A PARTY TO THE AGREEMENT MAY REQUEST THAT THE AUTHORITY RECONSIDER ITS DECISION. THE AUTHORITY SHALL RECONSIDER ITS DECISION IF THE PARTY APPLYING FOR RECONSIDERATION SUBMITS THE REQUEST TO THE AUTHORITY IN WRITING WITHIN 30 CALENDAR DAYS OF THE AUTHORITY'S DECISION TO DENY THE INITIAL APPLICATION.

(2) THE AUTHORITY SHALL HOLD A PUBLIC HEARING ON THE APPLICATION FOR RECONSIDERATION. THE HEARING MUST BE HELD WITHIN 30 DAYS OF RECEIPT OF THE REQUEST FOR RECONSIDERATION UNLESS THE PARTY APPLYING FOR RECONSIDERATION AGREES TO A HEARING AT A LATER TIME. THE HEARING MUST BE HELD PURSUANT TO 2-4-604.

(3) THE AUTHORITY SHALL MAKE A DECISION TO DENY THE APPLICATION OR TO ISSUE THE CERTIFICATE WITHIN 30 DAYS OF

1 THE CONCLUSION OF THE HEARING REQUIRED BY SUBSECTION (2).
 2 THE DECISION OF THE AUTHORITY MUST BE PART OF WRITTEN
 3 FINDINGS OF FACT AND CONCLUSIONS OF LAW SUPPORTING THE
 4 DECISION. THE FINDINGS, CONCLUSIONS, AND DECISION MUST BE
 5 SERVED UPON THE APPLICANT FOR RECONSIDERATION.

6 NEW SECTION. SECTION 41. REVOCATION OF CERTIFICATE BY
 7 AUTHORITY. (1) THE AUTHORITY SHALL REVOKE A CERTIFICATE
 8 PREVIOUSLY GRANTED BY IT IF THE AUTHORITY DETERMINES THAT
 9 THE COOPERATIVE AGREEMENT IS NOT RESULTING IN LOWER HEALTH
 10 CARE COSTS OR GREATER ACCESS TO OR QUALITY OF HEALTH CARE
 11 THAN WOULD OCCUR IN ABSENCE OF THE AGREEMENT.

12 (2) A CERTIFICATE MAY NOT BE REVOKED BY THE AUTHORITY
 13 WITHOUT GIVING NOTICE AND AN OPPORTUNITY FOR A HEARING
 14 BEFORE THE AUTHORITY AS FOLLOWS:

15 (A) WRITTEN NOTICE OF THE PROPOSED REVOCATION MUST BE
 16 GIVEN TO THE PARTIES TO THE AGREEMENT FOR WHICH THE
 17 CERTIFICATE WAS ISSUED AT LEAST 120 DAYS BEFORE THE
 18 EFFECTIVE DATE OF THE PROPOSED REVOCATION.

19 (B) A HEARING MUST BE PROVIDED PRIOR TO REVOCATION IF A
 20 PARTY TO THE AGREEMENT SUBMITS A WRITTEN REQUEST FOR A
 21 HEARING TO THE AUTHORITY WITHIN 30 CALENDAR DAYS AFTER
 22 NOTICE IS MAILED TO THE PARTY UNDER SUBSECTION (2)(A).

23 (C) WITHIN 30 CALENDAR DAYS OF RECEIPT OF THE REQUEST
 24 FOR A HEARING, THE AUTHORITY SHALL HOLD A PUBLIC HEARING TO
 25 DETERMINE WHETHER OR NOT TO REVOKE THE CERTIFICATE. THE

1 HEARING MUST BE HELD IN ACCORDANCE WITH 2-4-604.

2 (3) THE AUTHORITY SHALL MAKE ITS FINAL DECISION AND
 3 SERVE THE PARTIES WITH WRITTEN FINDINGS OF FACT AND
 4 CONCLUSIONS OF LAW IN SUPPORT OF ITS DECISION WITHIN 30 DAYS
 5 AFTER THE CONCLUSION OF THE HEARING OR, IF NO HEARING IS
 6 REQUESTED, WITHIN 30 DAYS OF THE DATE OF EXPIRATION OF THE
 7 TIME TO REQUEST A HEARING.

8 (4) IF A CERTIFICATE OF PUBLIC ADVANTAGE IS REVOKED BY
 9 THE AUTHORITY, THE AGREEMENT FOR WHICH THE CERTIFICATE WAS
 10 ISSUED IS TERMINATED.

11 NEW SECTION. SECTION 42. APPEAL. A PARTY TO A
 12 COOPERATIVE AGREEMENT MAY APPEAL, IN THE MANNER PROVIDED IN
 13 TITLE 2, CHAPTER 4, PART 7, A FINAL DECISION BY THE
 14 AUTHORITY TO DENY AN APPLICATION FOR A CERTIFICATE OR A
 15 DECISION BY THE AUTHORITY TO REVOKE A CERTIFICATE. A
 16 REVOCATION OF A CERTIFICATE PURSUANT TO [SECTION 41] DOES
 17 NOT BECOME FINAL UNTIL THE TIME FOR APPEAL HAS EXPIRED. IF A
 18 DECISION TO REVOKE A CERTIFICATE IS APPEALED, THE DECISION
 19 IS STAYED PENDING RESOLUTION OF THE APPEAL BY THE COURTS.

20 NEW SECTION. SECTION 43. RECORD OF AGREEMENTS TO BE
 21 KEPT. THE AUTHORITY SHALL KEEP A COPY OF COOPERATIVE
 22 AGREEMENTS FOR WHICH A CERTIFICATE IS IN EFFECT PURSUANT TO
 23 [SECTIONS 37 THROUGH 44]. A PARTY TO A COOPERATIVE AGREEMENT
 24 WHO TERMINATES THE AGREEMENT SHALL NOTIFY THE AUTHORITY IN
 25 WRITING OF THE TERMINATION WITHIN 30 DAYS AFTER THE

1 TERMINATION.

2 NEW SECTION. SECTION 44. RULEMAKING. THE AUTHORITY
 3 SHALL ADOPT RULES TO IMPLEMENT [SECTIONS 37 THROUGH 43]. THE
 4 RULES SHALL INCLUDE RULES:

5 (1) SPECIFYING THE FORM AND CONTENT OF APPLICATIONS FOR
 6 A CERTIFICATE;

7 (2) SPECIFYING NECESSARY DETAILS FOR RECONSIDERATION OF
 8 DENIAL OF CERTIFICATES, REVOCATIONS OF CERTIFICATES,
 9 HEARINGS REQUIRED OR AUTHORIZED BY [SECTIONS 37 THROUGH 43],
 10 AND APPEALS; AND

11 (3) TO EFFECT THE ACTIVE SUPERVISION BY THE AUTHORITY
 12 OF AGREEMENTS BETWEEN HEALTH CARE FACILITIES. THESE RULES
 13 MAY INCLUDE REPORTING REQUIREMENTS FOR PARTIES TO AN
 14 AGREEMENT FOR WHICH A CERTIFICATE IS IN EFFECT.

15 NEW SECTION. Section 45. Codification instructions.

16 (1) [Sections 1 through 20 AND 37 THROUGH 44] are intended
 17 to be codified as an integral part of Title 50, and the
 18 provisions of Title 50 apply to [sections 1 through 20 AND
 19 37 THROUGH 44].

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

23 NEW SECTION. SECTION 46. SEVERABILITY. IF A PART OF
 24 [THIS ACT] IS INVALID, ALL VALID PARTS THAT ARE SEVERABLE
 25 FROM THE INVALID PART REMAIN IN EFFECT. IF A PART OF [THIS

1 ACT] IS INVALID IN ONE OR MORE OF ITS APPLICATIONS, THE PART
 2 REMAINS IN EFFECT IN ALL VALID APPLICATIONS THAT ARE
 3 SEVERABLE FROM THE INVALID APPLICATIONS.

4 NEW SECTION. Section 47. Effective dates. (1)
 5 [Sections 1 through 20,--37, AND 44 THROUGH 46 and this
 6 section] are effective on passage and approval.

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

8 (3) [Sections 22 through 28, 35, AND 36] are effective
 9 January 1, 1994.

10 (4) [SECTIONS 30 THROUGH 34] ARE EFFECTIVE JULY 1,
 11 1993.

-End-