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

BILL NO. SB 285

INTRODUCED BY Senate Franklin

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; PROVIDING FOR THE POWERS AND DUTIES OF REGIONAL BOARDS; REQUIRING THE ESTABLISHMENT OF A UNIFIED HEALTH CARE DATA BASE; PROVIDING FOR HEALTH INSURANCE REFORM; TRANSFERRING TO THE AUTHORITY CERTAIN FUNCTIONS OF THE DEPARTMENT AND BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES RELATING TO VITAL STATISTICS; AMENDING SECTION 50-15-101, 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

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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

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

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

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

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

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

(4) "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.

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

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

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

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

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

NEW SECTION. **Section 3.** 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 shall prepare plans and options for consideration by the authority and implement plans as directed by the authority.

(2) The authority may employ professional and support staff necessary for the conduct of the business of the authority and the business of the boards and may employ 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

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 required in subsection (1);

(e) expenditure targets for health care providers;

(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, and health care facilities to educate the public concerning the purpose and content of the statewide plans.

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

(2) The management plan must:

(a) be prepared by the authority after consideration of

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

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

(c) include 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;

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

(e) include incentives for healthy lifestyles; and

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

NEW SECTION. **Section 7. 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;

(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

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 9. Long-term care study and recommendations.** 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 10]. The authority shall present its report to the legislature on or before January 1, 1997.

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

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

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

(3) 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 five 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.

(4) Regional board members serve 4-year terms, except that of the board members initially selected, one member serves for 2 years, two members serve for 3 years, and two 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 11.** Duties of boards. A board shall:

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

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

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

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

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

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

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

(8) conduct at least one annual public hearing to

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

NEW SECTION. **Section 12.** 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; and

(d) 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, and 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.

(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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Section 14.** Vital statistics transferred to authority. (1) The functions of the board of health and environmental sciences and the department of health and environmental sciences contained in Title 50, chapter 15, concerning vital statistics are transferred to the Montana 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

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

NEW SECTION. **Section 17.** Codification instruction. (1) [Section 1] is intended to be codified as an integral part of Title 2, chapter 15, and the provisions of Title 2, chapter 15, apply to [section 1].

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

2/10/93
EVE FRANKLIN, PRIMARY SPONSOR DATE
Fiscal Note for SB0285, as introduced

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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 resposibilities 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:

	FY '94			FY '95		
Montana Health Care Authority	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
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

* Ignores potential use of federal and foundation funds per assumptions 8 and 9.

	FY '94			FY '95		
State Auditor's Office	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
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.

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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.

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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.#2

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		
Montana Health Care Authority	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
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

* Ignores potential use of federal and foundation funds per assumptions 8 and 9.

	FY '94			FY '95		
State Auditor's Office	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
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

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

COMPATIBLE WITH ELECTRONIC DATA TRANSMISSION.

(4) [SECTION 19] 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.

(5) [SECTIONS 23, 26, 27, 30, AND 34 THROUGH 36] REQUIRE 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 PURSUANT TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION PERIOD TO ALLOW SMALL EMPLOYER CARRIERS TO COMPLY WITH CERTAIN PROVISIONS OF THE ACT. THE COMMISSIONER MAY APPROVE THE ESTABLISHMENT OF ADDITIONAL CLASSES OF BUSINESSES ONLY

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

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) promote rational allocation of health care resources in the state; and

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

NEW SECTION. **Section 2. Definitions.** For the purposes of [sections 1 through 20], 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) "Data base" means the unified health care data base created pursuant to [section 19].

(4) "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.

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

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

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

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

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

NEW SECTION. **Section 3. 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. 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

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 shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the target required in subsection (1), including 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 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 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 resources;

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

(vii) human resources;

(viii) major medical equipment; and

(ix) 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 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

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 on statewide plans.** 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.

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 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 presiding officer, but not less than quarterly;

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

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

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

(e) revise the regional plan annually;

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

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

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

authority; and

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

(2) Regional boards may:

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

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

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

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

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

statewide plans required by [section 5], the common benefits package, procedures for developing and applying practice guidelines for use in the statewide plans, provider and 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.

(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) "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.

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

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

(6) "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.

(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

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

(18) "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) "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

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 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 additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

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

insurance was issued.

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

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

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

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

(c) the provisions relating to renewability of policies

and contracts; and

(d) the provisions relating to any preexisting condition.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed 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 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

place the small employer carrier in a financially impaired condition.

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

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

(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of 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;

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

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

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

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

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

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

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

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

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

(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) 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 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.

(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.

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.

(2) The committee shall 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;

(ii) case management;

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

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

(v) other managed care provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) [Sections 22 through 36] are effective January 1, 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 ~~58-15-101~~ 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

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 E 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,"

3-30-93 10:40

Committee Vote:
Yes 15, No 0.

710952SC.Hss

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

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"

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

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

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

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~~

REFERENCE BILL
AS AMENDED

~~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

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

(4)(D) [SECTION 19] 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.

(5)(E) [SECTIONS 23, 26, 27, 30, 31, AND 34 THROUGH 36] REQUIRE 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 PURSUANT TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION

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

(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.

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;

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

~~(F)~~(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.

~~(3)~~(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.

~~(4)~~(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.

~~(5)~~(8) "Health insurer" means any health insurance

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

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

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

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

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

NEW SECTION. **Section 3.** **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. 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~~ SPEAKER and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The ~~majority~~ SPEAKER 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~~ PRESIDENT and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The ~~majority~~ PRESIDENT 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) 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

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) CONSIDERATION OF THE LIMITATIONS OF PUBLIC FUNDING;

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

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

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

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

~~(j)~~(K) policymaking for the system as a whole and accountability within state government;

~~(k)~~(L) incentives to be used to contain costs, PROVIDE MARKET CONTROL, and direct resources;

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

~~(m)~~(N) the appropriate use of midlevel practitioners, such as physician's assistants and nurse practitioners;

~~(n)~~(O) mechanisms for reducing the cost of prescription drugs, both as part of and as separate from the uniform benefit plan;

(P) INCENTIVES FOR MARKET CONTROL;

~~(o)~~(Q) 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)~~(R) an actuarially sound estimate of the costs of implementing the plan through the year 2005.

(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.

NEW SECTION. **Section 7.** Cost containment. (1) The statewide plans must contain a cost containment component, INCLUDING ANNUAL COST CONTAINMENT TARGETS. Except as otherwise provided in this section, each statewide plan must establish ~~a target~~ TARGETS 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 shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the ~~target~~ TARGETS required in subsection (1), including 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, 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

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 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~~ 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

presiding officer, but not less than quarterly;

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

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

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

(e) revise the regional plan annually;

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

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

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

(i) seek from ~~local~~ PUBLIC AND PRIVATE sources money to supplement grant funds provided by the authority.

(2) Regional boards may:

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

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

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

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

(3) Each regional board may review and advise the authority on regional technical matters relating to the statewide plans required by [section 5], the common benefits package, procedures for developing and applying practice guidelines for use in the statewide plans, provider and 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

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, 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.

~~(3)~~(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.

~~(4)~~(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to [section 31].

~~(5)~~(6) "Board" means the board of directors of the program established pursuant to [section 30].

~~(6)~~(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.

~~(7)~~(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].

~~(8)~~(9) "Class of business" means all or a separate

grouping of small employers established pursuant to [section 26].

~~(9)~~(10) "Committee" means the health benefit plan committee created pursuant to [section 31].

~~(10)~~(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.

~~(11)~~(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.

~~(12)~~(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 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

AS A GROUP are considered one employer.

~~(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 additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

NEW SECTION. **Section 27. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans under [sections 22 through 36] are subject to the following 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~~,~~;

(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)~~(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.

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

~~(k)~~(I) The commissioner ~~may~~ SHALL 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 insurance was issued.

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

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its

solicitation and sales materials, of each of the following:

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

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

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions relating to any preexisting condition.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed 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 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 employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of [sections 22 through 36].

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

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

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or

limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

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

(ii) A small employer carrier may vary the application

of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

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

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

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

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

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

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

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition.

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

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

(b) (i) In selecting the members of the board, the

commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of 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] AND ON OR BEFORE MARCH 1 OF EACH YEAR AFTER THAT DATE, each ~~small-employer~~ ASSESSABLE 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;

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

(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

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

(7) The program ~~must have~~ HAS the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to

transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program ~~must have the specific authority to~~ MAY:

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

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

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

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

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

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

(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;

(ii) case management;

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

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

(v) other managed care provisions.

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

NEW SECTION. **Section 32.** **Periodic market evaluation -- report.** The board, in consultation with members of the committee, shall study and report at least every 3 years to the commissioner on the effectiveness of [sections 22 through 36]. The report must analyze the effectiveness of [sections 22 through 36] in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively

marketing or issuing health benefit plans to small employers in fulfillment of the purposes of [sections 22 through 36]. The report may contain recommendations for market conduct or other regulatory standards or action.

NEW SECTION. **Section 33.** **Waiver of certain laws.** A law that requires the inclusion of a specific category of licensed health care ~~practitioner does~~ PRACTITIONERS AND A LAW THAT REQUIRES THE COVERAGE OF A HEALTH CARE SERVICE OR BENEFIT DO not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to [sections 22 through 36] 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].

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

NEW SECTION. **Section 35.** **Standards to ensure fair marketing.** (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage other than the basic or standard health benefit plans to a small employer on the basis of claims experience of the

small employer or the health status or claims experience of its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

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

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

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

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

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a

producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

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

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

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

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or

otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

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

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

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

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

NEW SECTION. **Section 36.** Restoration of terminated coverage. The commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after [the effective date of this section], to reissue a health benefit

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

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 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 [SECTIONS 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 WHICH A CERTIFICATE IS IN EFFECT.

NEW SECTION. **Section 45.** **Codification instructions.** (1) [Sections 1 through 20 AND 37 THROUGH 44] are intended to be codified as an integral part of Title 50, and the provisions of Title 50 apply to [sections 1 through 20 AND 37 THROUGH 44].

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

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.

NEW SECTION. **Section 47.** **Effective dates.** (1) [Sections 1 through 20~~,--37,~~ AND 44 THROUGH 46 and this section] are effective on passage and approval.

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

(3) [Sections 22 through 28, 35, AND 36] are effective

January 1, 1994.

(4) [SECTIONS 30 THROUGH 34] ARE EFFECTIVE JULY 1, 1993.

-End-

Conference Committee
on Senate Bill No. 285
Report No. 1, April 19, 1993

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:

Senator Franklin, Chair

Senator Brown

Senator Eck

For the House:

Representative Simon, Chair

Representative T. Nelson

Representative S. Rice

Amd. Coord.

Sec. of Senate

CCR #1
SB 285

SB 0285/04

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~~

REFERENCE BILL: Includes Conference Committee report Dated 4-19-93

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

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

~~(4)~~(D) [SECTION 19] 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.

~~(5)~~(E) [SECTIONS 23, 26, 27, 30, 31, AND 34 THROUGH 36] REQUIRE 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 PURSUANT TO THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT. THE COMMISSIONER MAY ADOPT RULES PROVIDING FOR A TRANSITION

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

(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~~ 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;

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

~~(F)~~(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.

~~(3)~~(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.

~~(4)~~(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.

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

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

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

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

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

NEW SECTION. **Section 3. 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. 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~~ SPEAKER and minority leader of the house of representatives shall select an individual with recognized expertise or interest, or both, in health care. The ~~majority~~ SPEAKER 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~~ PRESIDENT and minority leader of the senate shall select an individual with recognized expertise or interest, or both, in health care. The ~~majority~~ PRESIDENT 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) 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 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) CONSIDERATION OF THE LIMITATIONS OF PUBLIC FUNDING;

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

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

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

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

~~(j)~~(K) policymaking for the system as a whole and accountability within state government;

~~(k)~~(L) incentives to be used to contain costs~~;--PROVIDE MARKET-CONTROL;~~ and direct resources;

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

~~(m)~~(N) the appropriate use of midlevel practitioners, such as physician's assistants and nurse practitioners;

~~(n)~~(O) mechanisms for reducing the cost of prescription drugs, both as part of and as separate from the uniform benefit plan;

~~(P)--INCENTIVES-FOR-MARKET-CONTROL;~~

~~(o)~~~~(Q)~~(P) 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)~~(R)(Q) an actuarially sound estimate of the costs of implementing the plan through the year 2005.

(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.

NEW SECTION. **Section 7.** **Cost containment.** (1) The statewide plans must contain a cost containment component, INCLUDING ANNUAL COST CONTAINMENT TARGETS. Except as otherwise provided in this section, each statewide plan must establish ~~a--target~~ TARGETS 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 shall adopt processes and criteria for responding to exceptional and unforeseen circumstances that affect the health care system and the ~~target~~ TARGETS required in subsection (1), including 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, 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 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 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~~ 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 presiding officer, but not less than quarterly;

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

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

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

(e) revise the regional plan annually;

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

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

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

(i) seek from ~~local~~ PUBLIC AND PRIVATE sources money to supplement grant funds provided by the authority.

(2) Regional boards may:

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

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

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

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

(3) Each regional board may review and advise the authority on regional technical matters relating to the statewide plans required by [section 5], the common benefits package, procedures for developing and applying practice guidelines for use in the statewide plans, provider and

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 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.

~~(3)~~(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.

~~(4)~~(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to [section 31].

~~(5)~~(6) "Board" means the board of directors of the program established pursuant to [section 30].

~~(6)~~(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.

~~(7)~~(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].

~~(8)~~(9) "Class of business" means all or a separate grouping of small employers established pursuant to [section 26].

~~(9)~~(10) "Committee" means the health benefit plan committee created pursuant to [section 31].

~~(10)~~(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.

~~(11)~~(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.

~~(12)~~(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

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 CONSIDERED ONE EMPLOYER IF THEY:

(A) are affiliated companies ~~or that~~;

(B) are eligible to file a combined tax return for 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

additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

NEW SECTION. **Section 27.** **Restrictions relating to premium rates.** (1) Premium rates for health benefit plans under [sections 22 through 36] are subject to the following 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~~.~~;

(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)~~(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.

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

~~(k)~~(I) The commissioner ~~may~~ SHALL 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 insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer

carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

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

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

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

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions relating to any preexisting condition.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed 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

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

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

(a) A health benefit plan may not, because of a

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

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

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier

in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

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

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

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to

offer coverage or accept applications pursuant to subsection (1) in the case of the following:

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

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

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

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition.

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

health reinsurance program.

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

(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of 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] AND ON OR BEFORE MARCH 1 OF EACH YEAR AFTER THAT DATE, each ~~small-employer~~ ASSESSABLE 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;

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

(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

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

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

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

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

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

(d) define the health benefit plans for which

reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of [sections 22 through 36];

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

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

(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;

(ii) case management;

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

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

(v) other managed care provisions.

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

NEW SECTION. **Section 32.** **Periodic market evaluation -- report.** The board, in consultation with members of the committee, shall study and report at least every 3 years to

the commissioner on the effectiveness of [sections 22 through 36]. The report must analyze the effectiveness of [sections 22 through 36] in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of [sections 22 through 36]. The report may contain recommendations for market conduct or other regulatory standards or action.

NEW SECTION. **Section 33.** **Waiver of certain laws.** A law that requires the inclusion of a specific category of licensed health care ~~practitioner does~~ PRACTITIONERS AND A LAW THAT REQUIRES THE COVERAGE OF A HEALTH CARE SERVICE OR BENEFIT DO not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to [sections 22 through 36] 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].

NEW SECTION. **Section 34.** **Administrative procedure.** The commissioner shall adopt rules in accordance with the Montana Administrative Procedure Act to implement and

administer [sections 22 through 36].

NEW SECTION. **Section 35.** **Standards to ensure fair marketing.** (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage other than the basic or standard health benefit plans to a small employer on the basis of claims experience of the small employer or the health status or claims experience of its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

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

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

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

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

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

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

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

(5) A small employer carrier may not terminate, fail to

renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

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

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

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

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related

to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier.

NEW SECTION. **Section 36.** Restoration of terminated coverage. The commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after [the effective date of this section], to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after [6 months prior to the effective date of this section]. The commissioner may prescribe the terms for the reissuance of coverage that the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

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 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 [SECTIONS 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 WHICH A CERTIFICATE IS IN EFFECT.

NEW SECTION. **Section 45.** Codification instructions. (1) [Sections 1 through 20 AND 37 THROUGH 44] are intended to be codified as an integral part of Title 50, and the provisions of Title 50 apply to [sections 1 through 20 AND 37 THROUGH 44].

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

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.

NEW SECTION. **Section 47.** Effective dates. (1) [Sections 1 through 20~~,~~--37~~,~~ AND 44 THROUGH 46 and this section] are effective on passage and approval.

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

(3) [Sections 22 through 28, 35, AND 36] are effective January 1, 1994.

(4) [SECTIONS 30 THROUGH 34] ARE EFFECTIVE JULY 1, 1993.

-End-