House BILL NO. 511

INTRODUCED BY L. Johnson

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE HEALTH CARE ADVISORY COUNCIL; PROVIDING FOR MEMBERSHIP, MEETINGS, COORDINATION, AND STAFF SUPPORT; PROVIDING FOR A TRANSITIONAL MEETING BETWEEN THE HEALTH CARE ADVISORY COUNCIL AND THE MONTANA HEALTH CARE AUTHORITY; MAINTAINING THE RESPONSIBILITY OF THE STATE HEALTH PLAN WITH THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; ELIMINATING THE MONTANA HEALTH CARE AUTHORITY; AMENDING SECTIONS 33-22-1809 AND 50-1-201, MCA; REPEALING SECTIONS 50-4-101, 50-4-102, 50-4-201, 50-4-202, 50-4-301, 50-4-302, 50-4-303, 50-4-305, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, 50-4-401, 50-4-402, 50-4-501, 50-4-502, 50-4-503, 50-4-601, 50-4-602, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612, MCA, AND SECTION 21, CHAPTER 606, LAWS OF 1993; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE."

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

NEW SECTION. **Section 1. Purpose.** (1) The people of Montana have evaluated and rejected both the single payor and multiple payor health care reform plans developed by the Montana health care authority. However, the public has also recognized the continued need for evaluation and analysis of Montana's health care system. The public supports an incremental private-sector approach to health care reform with an emphasis on affordability and on access to health care. The health care advisory council is created to continue the public-private partnership in order to develop initiatives regarding health care reform to be presented to the 1997 legislature.

(2) The health care advisory council shall monitor and evaluate implementation of recent health care reform initiatives, including small group insurance reform, the development of medicaid managed care, tort reform, changes to the antitrust statutes, voluntary purchasing pools, and the efficiency of the certificate of need process. The health care advisory council shall provide reports on the progress of these reforms to the general public and to the legislature.

NEW SECTION. **Section 2. Health care advisory council.** (1) There is a health care advisory

council.

(2) The health care advisory council is composed of 10 members. The members must be selected by May 1, 1995.

(a) There are four legislative members. Two members must be selected by the president of the senate from a pool of applicants from the senate, one representing each party. Two members must be selected by the speaker of the house from a pool of applicants from the house of representatives, one representing each party.

(b) There are five members, each representing a health care planning region as provided in [section 6], selected by the governor from a pool of applicants.

(c) There is one member representing the executive branch of government, appointed by the governor.

(3) Legislators and regional board members who want to serve on the health care advisory council shall apply to the president of the senate, speaker of the house, or governor, respectively, for a position on the council. The application must include:

(a) a statement of the reason that the person wishes to serve on the council;

(b) the experience that qualifies the person to serve; and

(c) a statement of the person's willingness to commit the substantial time required to serve on the council.

(4) The members of the health care advisory council shall elect a presiding officer from among the members.

(5) A vacancy on the health care advisory council must be filled in the same manner as the original appointment.

NEW SECTION. **Section 3. Meetings.** (1) The health care advisory council may meet up to 10 times over the biennium.

(2) The council shall adopt rules of procedure for the conduct of the meetings.

NEW SECTION. **Section 4. Reimbursement of expenses -- compensation.** (1) The member of the health care advisory council who is appointed by the governor is entitled to reimbursement for expenses as provided in 2-18-501 through 2-18-503.

(2) A legislative member is entitled to compensation and expenses as provided in 5-2-302.

NEW SECTION. **Section 5. Powers and duties -- report -- staff support.** (1) The health care advisory council shall study the considerations outlined in [section 1] and shall continue the study of solutions to the health care crisis and study methods of cost reduction in health care services and health care delivery systems.

(2) The health care advisory council shall report its findings to the governor and the legislature by October 1, 1996.

(3) The health care advisory council is the repository of all documents and materials of the Montana health care authority.

(4) The department of social and rehabilitation services shall provide staff support to the health care advisory council.

(5) The health care advisory council is attached to the department of social and rehabilitation services for administrative purposes only as provided in 2-15-121.

(6) The department of social and rehabilitation services, the department of health and environmental sciences, the commissioner of insurance, and the attorney general shall provide information to the health care advisory council as necessary.

NEW SECTION. Section 6. **Health care planning regions.** For the purpose of determining members of the health care advisory council, there are five health care planning regions that consist of the following counties:

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

(2) region II: Blaine, Hill, Liberty, Toole, Glacier, Phillips, Pondera, Teton, Chouteau, and Cascade;

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

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

(5) region V: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli.

NEW SECTION. **Section 7. Transition from Montana health care authority study.** (1) The members of the health care advisory council and the members of the Montana health care authority shall hold one meeting before June 30, 1995. The meeting must be staffed by the Montana health care authority and the department of social and rehabilitation services.

(2) On or before June 30, 1995, the documents and materials compiled by the Montana health care authority must be transferred to the health care advisory council.

Section 8. Section 33-22-1809, MCA, is amended to read:

"33-22-1809. Restrictions relating to premium rates. (1) Premium rates for health benefit plans under this part 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 50-4-201 certifies to the commissioner that the cost containment goal set forth in 50-4-303 is met on or before January 1, 1998, 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) 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.

(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 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.

(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.

(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.

(i) The commissioner 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 this part, 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 this part 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 this part 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."

Section 9. Section 50-1-201, MCA, is amended to read:

"**50-1-201. ~~(Temporary)~~ Administration of state health plan.** The department is ~~hereby established as~~ the ~~sole and official~~ state agency to administer the state program for comprehensive health planning and ~~is hereby authorized to~~ may prepare a plan for comprehensive state health planning. The department ~~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, 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~~ may accept, receive, expend, and administer ~~any and all~~ funds ~~which~~ that 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.

~~**50-1-201. (Effective July 1, 1996) Administration of state health plan.** The Montana health care authority created in 50-4-201 is the state agency to administer the state program for comprehensive health planning and shall prepare a plan for comprehensive state health planning. The authority may confer and cooperate with other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The authority, while acting in this capacity as the state agency to administer and~~

~~supervise the administration of the official comprehensive state health plan, is designated and authorized as the state agency to accept, receive, expend, and administer funds donated, granted, bequeathed, or appropriated to it for the preparation, administration, and supervision of the preparation and administration of the comprehensive state health plan.~~"

NEW SECTION. **Section 10. Repealer.** Sections 50-4-101, 50-4-102, 50-4-201, 50-4-202, 50-4-301, 50-4-302, 50-4-303, 50-4-305, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, 50-4-401, 50-4-402, 50-4-501, 50-4-502, 50-4-503, 50-4-601, 50-4-602, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, and 50-4-612, MCA, and section 21, Chapter 606, Laws of 1993, are repealed.

NEW SECTION. **Section 11. Codification instruction.** [Sections 1 through 6] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [sections 1 through 6].

NEW SECTION. **Section 12. Coordination instruction.** If ___ Bill No. ____ [LC 935] is passed and approved, then the department of public health and human services shall provide staff support to the health care advisory council and the council must be administratively attached to the department of public health and human services as provided in 2-15-121.

NEW SECTION. **Section 13. Effective dates.** (1) [Sections 1 through 7, 11, 12, and 14 and this section] are effective on passage and approval.

(2) [Sections 8 through 10] are effective July 1, 1995.

NEW SECTION. **Section 14. Termination.** [Sections 1 through 7] terminate June 30, 1997.

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0511, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
An act creating the Health Care Advisory Council; providing for a transitional meeting between the Health Care Advisory Council and the Montana Health Care Authority; maintaining the responsibility for the state health plan with the Department of Health and Environmental Sciences (DHES); and eliminating the Montana Health Care Authority.

ASSUMPTIONS:
1. The Executive Budget present law base serves as the starting point from which to calculate any fiscal impact due to this proposed legislation, with the exception of the present law proposal to transfer Certificate of Need (CON) to the Health Care Authority. For purposes of this fiscal note, it is assumed that the present law CON will be moved from the Health Care Authority back into DHES, since the statutory requirement for the program still remains. The CON present law base would be adjusted in HB2 to reflect this assumption upon passage and approval of HB511.
2. The advisory council will have 1.00 FTE, grade 15. Operating costs for this person will be $1,840 each year of the biennium.
3. There will be five meetings of the ten-member council each year, for a total of 10 meetings during the biennium. Total operating costs for the meetings are estimated to be $8,575 per year, broken down as follows:
   - Per diem will be $15.50 per person assuming five one-day meetings per year, for an annual total of $775 ($15.50 X 10 X 5)
   - Lodging will be $30 per person, assuming five members per meeting will need to stay overnight, for an annual total of $750.
   - Mileage is based on each of the ten members travelling an average of 400 miles round trip at $.29 per mile for each meeting. The annual total is $5,800.
   - An honorarium of $25 is paid to each member at each meeting, for an annual total cost of $1,250.
4. No new studies will be undertaken. Studies to be reviewed are listed in section one of the bill. No funds for contracted services have been included for studies.

FISCAL IMPACT:
Expenditures:

	FY96 Difference	FY97 Difference
FTE	(2.00)	(2.00)
Personal Services	(105,819)	(106,250)
Operating Expenses	(274,846)	(199,296)
Total Expenses	(380,665)	(305,546)
Funding:		
General Fund (01)	(152,833)	(77,773)
State Special (02)	(250,000)	(250,000)
Federal Fund (03)	22,168	22,227
Total Funds	(380,665)	(305,546)
Total Net Impact on General Fund Balance:		
General Fund Savings (01)	152,833	77,773

Dave Lewis 2-17-95
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

ROYAL JOHNSON, PRIMARY SPONSOR DATE

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0511, reference bill as amended

DESCRIPTION OF PROPOSED LEGISLATION:
An act creating the health care advisory council; providing for membership, meetings, coordination, and staff support; providing for a transitional meeting between the Health Care Advisory Council (HCAC) and the Montana Health Care Authority (MHCA); maintaining the responsibility of the state health plan with the Department of Health and Environmental Sciences (DHES); transferring the responsibility for the health care data base to the Department of Social and Rehabilitation Services (SRS); and transferring the responsibility for certificates of public advantage to the Department of Justice (DOJ).

ASSUMPTIONS:
1. Under current law, the Attorney General is an ex-officio member of the MHCA 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. Under HB511, the DOJ under the Attorney General would assume these responsibilities.
2. In order for collaborative activity between health care facilities to be immune from federal antitrust restrictions, there must be a clearly articulated state policy to replace competition with regulation and the state must actively supervise the regulated conduct. Sections 50-4-601 through -612, MCA, clearly articulate the state policy for regulation, but active supervision will require thorough review of any proposed cooperative agreement and its impacts on the relevant markets, periodic review and monitoring of the effects of the cooperative agreement, and the ability to revoke the agreement if the anticipated benefits do not outweigh the effects of the anti-competitive conduct.
3. One or two cooperative agreements are anticipated to occur each year, with each requiring at least three months of full-time work by one attorney and one paralegal and the need for contracted economist services. In addition, review of monthly reporting will be necessary to satisfy the antitrust elements of assumption #2.
4. To perform the legal analysis and review along with the ongoing duties, DOJ will need 2.50 FTE (grade 19 - attorney; grade 10 - administrative support; 0.50 FTE grade 14 - paralegal). The personal services cost will be $86,300 in FY96 and $86,600 in FY97. Operating costs are estimated at $10,400 in FY96 and FY97. These costs cover additional rent (assume in state building), supplies, phone, etc. One-time-only equipment costs of $7,500 (2.50 FTE x $3,000 each) would be incurred in FY96 only for normal office equipment.
5. Assuming that the Attorney General's staff will perform all the duties enumerated above, it is generally believed that it is cost efficient to the state to have a continuous staff rather than contract out services when they occur.
6. SRS (or the Department of Public Health and Human Services (PHHS) if SB345 is enacted) will absorb responsibility for staff support and actual program requirements associated with this bill in its amended form.
7. The Executive Budget contained a recommendation to provide $425,000 in FY96 ($175,000 general fund and $250,000 in state special revenue spending authority in anticipation of receiving Robert Wood Johnson grants, which were subsequently turned down) and $350,000 in FY97 ($100,000 in general fund and $250,000 in state special revenue spending authority) to fund the MHCA during the 1997 biennium. The Executive also included a recommendation to reduce general fund by $11,751 in FY96 and $11,827 in FY97 for purposes of funding the pay plan. Both of these recommendations were removed from the budget by legislative action, and the MHCA currently has no funding for the 1997 biennium. As a result, there are currently no funds in HB2 to carry out any of the provisions of HB511.

(continued)

Dave Lewis 3-30-95

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

ROYAL JOHNSON, PRIMARY SPONSOR DATE

8. HB511 eliminates the MHCA effective FY96, which has no fiscal impact since there is no funding currently included in HB2 for the MHCA.
9. One FTE, grade 16 will be hired by SRS to staff this committee. Operating costs and equipment for this person total $5,840 in FY96 and $1,840 in FY97.
10. There will be ten meetings of the ten member council over the biennium, five meetings each fiscal year. Per diem will be $15.50 per person per day, plus lodging at $30 per person for five members. Assume each member will travel an average of 200 miles (one way), at 29 cents per mile, for each meeting. Assume honorariums paid to members will be $25 per member per meeting.
11. It is estimated that the cost to design and develop the data base on health care resources to measure the cost and quality of health services will be $250,000 in FY96 only. This is funded with $150,000 general fund and $100,000 federal funds.

FISCAL IMPACT:

Department of Justice, Legal Services

Expenditures:	FY96 Difference	FY97 Difference
FTE	2.50	2.50
Personal services	86,300	86,600
Operating expenses	10,400	10,400
Equipment	7,500	0
Total Expenditures	104,200	97,000
Funding:		
General Fund (01)	104,200	97,000

Department of Social and Rehabilitation Services

Expenditures:	FY96 Difference	FY97 Difference
FTE	1.00	1.00
Personal services	33,920	34,039
Operating expenses	260,415	10,415
Equipment	4,000	0
Total Expenditures	298,335	44,454
Funding:		
General Fund (01)	174,168	22,227
Federal Funds (03)	124,167	22,227
Total Funding	298,335	44,454
Net Impact to General Fund:		
General Fund Savings (Cost) (01)	(278,368)	(119,227)

Net Impact to General Fund if both HB509 and HB511 pass:

General Fund Savings (Cost) (01)	(174,168)	(22,227)

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
If litigation is required in the next biennium, additional legal assistance for DOJ may be required.

(continued)

INFORMATIONAL NOTE:
HB509 authorizes fees, to be paid to the MHCA, to cover the costs of administering 50-4-601 through -612, MCA. If HB509 is passed and approved, the MHCA will collect fees and reimburse DOJ for the cost of analyzing and reviewing the cooperative agreements. This will reduce the cost of HB511 to the amounts listed below.

Expenditures:	FY96 Difference	FY97 Difference
FTE	1.00	1.00
Personal services	33,920	34,039
Operating expenses	260,415	10,415
Equipment	4,000	0
Total Expenditures	298,335	44,454
Funding:		
General Fund (01)	174,168	22,227
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The net impact to the general fund under this scenario is listed above under the Net Impact to General Fund if both HB509 and HB511 pass section.

APPROVED BY SELECT
COMMITTEE ON HEALTH CARE

HOUSE BILL NO. 511

INTRODUCED BY R. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE HEALTH CARE ADVISORY COUNCIL; PROVIDING FOR MEMBERSHIP, MEETINGS, COORDINATION, AND STAFF SUPPORT; PROVIDING FOR A TRANSITIONAL MEETING BETWEEN THE HEALTH CARE ADVISORY COUNCIL AND THE MONTANA HEALTH CARE AUTHORITY; MAINTAINING THE RESPONSIBILITY OF THE STATE HEALTH PLAN WITH THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; ELIMINATING THE MONTANA HEALTH CARE AUTHORITY; TRANSFERRING THE RESPONSIBILITY FOR THE HEALTH CARE DATA BASE TO THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES; TRANSFERRING THE RESPONSIBILITY FOR CERTIFICATES OF PUBLIC ADVANTAGE TO THE DEPARTMENT OF JUSTICE; AMENDING SECTIONS 33-22-1809 ~~AND 50-1-201~~, 50-4-502, 50-4-601, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612, MCA; REPEALING SECTIONS 50-1-201, 50-4-101, 50-4-102, 50-4-201, 50-4-202, 50-4-301, 50-4-302, 50-4-303, 50-4-304, 50-4-305, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, 50-4-401, 50-4-402, 50-4-501, ~~50-4-502,~~ AND 50-4-503, ~~50-4-601, 50-4-602, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612,~~ MCA, AND SECTION 21, CHAPTER 606, LAWS OF 1993; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE."

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(2) The health care advisory council shall monitor and evaluate implementation of recent health care reform initiatives, including small group insurance reform, the development of medicaid managed care, tort reform, changes to the antitrust statutes, voluntary purchasing pools, and the efficiency of the certificate

of need process. The health care advisory council shall provide reports on the progress of these reforms to the general public and to the legislature.

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(2) The health care advisory council is composed of 10 members. The members must be selected by May 1, 1995.

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(b) There are five members, each representing a health care planning region as provided in [section 6], selected by the governor from a pool of applicants.

(c) There is one member representing the executive branch of government, appointed by the governor.

(3) Legislators and ~~regional board~~ members WHO REPRESENT HEALTH CARE PLANNING REGIONS AND who want to serve on the health care advisory council shall apply to the president of the senate, speaker of the house, or governor, respectively, for a position on the council. The application must include:

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(b) the experience that qualifies the person to serve; and

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(6) The department of social and rehabilitation services, the department of health and environmental sciences, the commissioner of insurance, and the attorney general shall provide information to the health care advisory council as necessary.

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

(2) region II: Blaine, Hill, Liberty, Toole, Glacier, Phillips, Pondera, Teton, Chouteau, and Cascade;

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

(4) region IV: Lewis and Clark, Powell, Granite, Deer Lodge, Silver Bow, Jefferson, Broadwater,

Meagher, Park, Gallatin, Madison, and Beaverhead;

(5) region V: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli.

NEW SECTION. **Section 7. Transition from Montana health care authority study.** (1) The members of the health care advisory council and the members of the Montana health care authority shall hold one meeting before June 30, 1995. The meeting must be staffed by the Montana health care authority and the department of social and rehabilitation services.

(2) On or before June 30, 1995, the documents and materials compiled by the Montana health care authority must be transferred to the health care advisory council.

Section 8. Section 33-22-1809, MCA, is amended to read:

"**33-22-1809. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans under this part 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 50-4-201 certifies to the commissioner that the cost containment goal set forth in 50-4-303 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) 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.

(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 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.

(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.

(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.

(i) The commissioner 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 this part, 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 this part 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 this part 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."

~~**Section 9.** Section 50-1-201, MCA, is amended to read:~~

~~"**50-1-201. (Temporary) Administration of state health plan.** The department is hereby established as the sole and official state agency to administer the state program for comprehensive health planning and is hereby authorized to may prepare a plan for comprehensive state health planning. The department 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, 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 may accept, receive, expend, and administer any and all funds which that 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.~~

~~**50-1-201. (Effective July 1, 1996) Administration of state health plan.** The Montana health care authority created in 50-4-201 is the state agency to administer the state program for comprehensive health~~

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

SECTION 9. SECTION 50-4-502, MCA, IS AMENDED TO READ:

"**50-4-502. Health care data base -- information submitted ~~-- enforcement~~.** (1) The ~~authority~~ department, with advice from the health care advisory council, shall design and 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~~ that includes data on health care resources and the cost and quality of health care services. The purpose of the data base is to assist in developing and monitoring the progress of incremental health care reform measures that increase access to health care services, promote cost containment, and maintain quality of care.

(2) The ~~authority~~ department shall ~~by rule require~~ work in conjunction with 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~~ determine the information 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)~~(3) The ~~authority~~ department 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.

(4) The department shall make recommendations to the legislature by October 1, 1996, on the actions needed to establish the data base, including an estimate of the fiscal impact on state and local government, health care providers, health insurers, health care facilities, and private entities."

NEW SECTION. **SECTION 10. DEFINITIONS.** AS USED IN THIS PART, THE FOLLOWING DEFINITIONS APPLY:

(1) "DATA BASE" MEANS THE HEALTH CARE DATA BASE CREATED PURSUANT TO 50-4-502.

(2) "DEPARTMENT" MEANS THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES PROVIDED FOR IN TITLE 2, CHAPTER 15, PART 22.

(3) "HEALTH CARE" INCLUDES BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

(4) "HEALTH CARE ADVISORY COUNCIL" MEANS THE COUNCIL PROVIDED FOR IN [SECTIONS 1 THROUGH 6].

(5) "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.

(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) "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.

SECTION 11. SECTION 50-4-601, MCA, IS AMENDED TO READ:

"**50-4-601. 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 this part is to provide the state, through the ~~authority~~ department, 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."

SECTION 12. SECTION 50-4-603, MCA, IS AMENDED TO READ:

"**50-4-603. Certificate of public advantage -- standards for certification -- time for action by ~~authority~~ department.** (1) Parties to a cooperative agreement may apply to the ~~authority~~ department 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~~ department shall hold a public hearing on the application for a certificate before acting upon the application. The ~~authority~~ department may not issue a certificate unless the ~~authority~~ department 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~~ department denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the ~~authority~~ department not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

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

SECTION 13. SECTION 50-4-604, MCA, IS AMENDED TO READ:

"**50-4-604. Reconsideration by ~~authority~~ department.** (1) If the ~~authority~~ department denies an application and refuses to issue a certificate, a party to the agreement may request that the ~~authority~~ department reconsider its decision. The ~~authority~~ department shall reconsider its decision if the party applying for reconsideration submits the request to the ~~authority~~ department in writing within 30 calendar days of the ~~authority's~~ department's decision to deny the initial application.

(2) The ~~authority~~ department 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~~ department 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~~ department 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."

SECTION 14. SECTION 50-4-609, MCA, IS AMENDED TO READ:

"**50-4-609. Revocation of certificate by ~~authority~~ department.** (1) The ~~authority~~ department shall revoke a certificate previously granted by it if the ~~authority~~ department 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~~ department without giving notice and an opportunity for a hearing before the ~~authority~~ department 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~~ department 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~~ department 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~~ department 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~~ department, the agreement for which the certificate was issued is terminated."

SECTION 15. SECTION 50-4-610, MCA, IS AMENDED TO READ:

"**50-4-610. 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~~ department to deny an application for a certificate or a decision by the ~~authority~~ department to revoke a certificate. A revocation of a certificate pursuant to 50-4-609 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."

SECTION 16. SECTION 50-4-611, MCA, IS AMENDED TO READ:

"**50-4-611. Record of agreements to be kept.** The ~~authority~~ department shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to this part. A party to a cooperative agreement who terminates the agreement shall notify the ~~authority~~ department in writing of the termination within 30 days after the termination."

SECTION 17. SECTION 50-4-612, MCA, IS AMENDED TO READ:

"50-4-612. **Rulemaking.** The ~~authority~~ department shall adopt rules to implement this part. 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 this part, and appeals; and

(3) to effect the active supervision by the ~~authority~~ department 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 18. DEFINITIONS.** FOR THE PURPOSES OF THIS PART, THE FOLLOWING DEFINITIONS APPLY:

(1) "CERTIFICATE OF PUBLIC ADVANTAGE" OR "CERTIFICATE" MEANS A WRITTEN CERTIFICATE ISSUED BY THE DEPARTMENT AS EVIDENCE OF THE DEPARTMENT'S INTENTION THAT THE IMPLEMENTATION OF A COOPERATIVE AGREEMENT, WHEN ACTIVELY SUPERVISED BY THE DEPARTMENT, RECEIVE STATE ACTION IMMUNITY FROM PROSECUTION AS A VIOLATION OF STATE OR FEDERAL ANTITRUST LAWS.

(2) "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) "DEPARTMENT" MEANS THE DEPARTMENT OF JUSTICE PROVIDED FOR IN TITLE 2, CHAPTER 15, PART 20.

(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.

NEW SECTION. **Section 19. Repealer.** Sections 50-1-201, 50-4-101, 50-4-102, 50-4-201, 50-4-202, 50-4-301, 50-4-302, 50-4-303, 50-4-304, 50-4-305, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, 50-4-401, 50-4-402, 50-4-501, ~~50-4-502,~~ AND 50-4-503, ~~50-4-601, 50-4-602, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, and 50-4-612,~~ MCA, and section 21, Chapter 606, Laws of 1993, are repealed.

NEW SECTION. **SECTION 20. NAME CHANGE -- DIRECTIONS TO CODE COMMISSIONER.** WHEREVER THE NAME OF OR A REFERENCE TO THE MONTANA HEALTH CARE AUTHORITY APPEARS IN LEGISLATION ENACTED BY THE 1995 LEGISLATURE TO BE CODIFIED IN TITLE 50, CHAPTER 4, PART 6, THE CODE COMMISSIONER IS DIRECTED TO CHANGE THE REFERENCE TO THE DEPARTMENT OF JUSTICE.

NEW SECTION. **Section 21. Codification ~~instruction.~~ INSTRUCTIONS.** (1) [Sections 1 through 6] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [sections 1 through 6].

(2) [SECTION 10] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 50, CHAPTER 4, PART 5, AND THE PROVISIONS OF TITLE 50, CHAPTER 4, PART 5, APPLY TO [SECTION 10].

(3) [SECTION 18] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 50, CHAPTER 4, PART 6, AND THE PROVISIONS OF TITLE 50, CHAPTER 4, PART 6, APPLY TO [SECTION 18].

NEW SECTION. **Section 22. Coordination instruction.** If ___ Bill No. ____ [LC 935] is passed and approved, then the department of public health and human services shall provide staff support to the health care advisory council and the council must be administratively attached to the department of public health and human services as provided in 2-15-121.

NEW SECTION. **Section 23. Effective dates.** (1) [Sections 1 through 7, ~~11, 12, and 14~~ 20 THROUGH 22, AND 24 and this section] are effective on passage and approval.

(2) [Sections 8 through ~~10~~ 19] are effective July 1, 1995.

NEW SECTION. **Section 24. Termination.** [Sections 1 through 7] terminate June 30, 1997.

-END-

HOUSE BILL NO. 511

INTRODUCED BY R. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE HEALTH CARE ADVISORY COUNCIL; PROVIDING FOR MEMBERSHIP, MEETINGS, COORDINATION, AND STAFF SUPPORT; PROVIDING FOR A TRANSITIONAL MEETING BETWEEN THE HEALTH CARE ADVISORY COUNCIL AND THE MONTANA HEALTH CARE AUTHORITY; MAINTAINING THE RESPONSIBILITY OF THE STATE HEALTH PLAN WITH THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; ELIMINATING THE MONTANA HEALTH CARE AUTHORITY; TRANSFERRING THE RESPONSIBILITY FOR THE HEALTH CARE DATA BASE TO THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES; TRANSFERRING THE RESPONSIBILITY FOR CERTIFICATES OF PUBLIC ADVANTAGE TO THE DEPARTMENT OF JUSTICE; AMENDING SECTIONS 33-22-1809 ~~AND 50-1-201~~, 50-4-502, 50-4-601, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612, MCA; REPEALING SECTIONS 50-1-201, 50-4-101, 50-4-102, 50-4-201, 50-4-202, 50-4-301, 50-4-302, 50-4-303, 50-4-304, 50-4-305, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, 50-4-401, 50-4-402, 50-4-501, ~~50-4-502,~~ AND 50-4-503, ~~50-4-601, 50-4-602, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612,~~ MCA, AND SECTION 21, CHAPTER 606, LAWS OF 1993; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE."

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

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

SENATE STANDING COMMITTEE REPORT

MR. PRESIDENT:

We, your Joint Select Committee on Health Care having had under consideration HB 511 (third reading copy -- blue), respectfully report that HB 511 be amended as follows and as so amended be concurred in.

Signed: _____
Senator Steve Benedict, Chair

That such amendments read:

1. Page 1, lines 21 through 23.
Following: "(1)"
Strike: the remainder of line 21 through "However," on line 23
Insert: "The legislature and"

2. Page 1, line 23.
Strike: "has also"
Insert: "have"

3. Page 1, line 24.
Following: "The"
Insert: "legislature and the"
Strike: "supports"
Insert: "support"

4. Page 2, line 3.
Insert: "

NEW SECTION. **Section 2. State health care policy.** (1) It is the policy of the state of Montana to continue to investigate and develop strategies that result in all residents having access to quality health services at costs that are affordable.

(2) It is further the policy of the state of Montana that:

(a) Montana's health care system should ensure that care is delivered in the most effective and efficient manner possible;

(b) health promotion, preventative health services, and public health services should play a central role in the system;

(c) the patient-provider relationship should be a fundamental component of Montana's health care system;

(d) individuals should be encouraged to play a significant role in determining their health and appropriate use of the health care system;

(e) accurate and timely health care information should play a significant role in determining the individual's health and appropriate use of the health care system;

(f) whenever possible, market-based approaches should be

Amd. Coord. _____ Sen. Jacobson
Sec. of Senate Senator Carrying Bill

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relied on to contain the growth in health care spending while attempting to achieve expanded access, cost containment, and improved quality; and

(g) the process of health care reform in Montana should be carried out gradually and sequentially to ensure that any undesirable impacts of the state's reform policies on other aspects of the state's economy, particularly on small businesses, are minimized.

(3) The legislature recognizes the need to increase the 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 those services to the consumer that are reasonable and necessary.

(4) [Sections 1 through 7] may not be interpreted to prevent Montana residents from seeking health care services not otherwise recommended or provided for as a result of the provisions of [sections 1 through 7]."
Renumber: subsequent sections

5. Page 9, line 28.
Strike: "6"
Insert: "7"

6. Page 14, lines 14 and 15.
Strike: "6"
Insert: "7"

7. Page 14, lines 16 and 17.
Strike: "10"
Insert: "11"

8. Page 14, lines 18 and 19.
Strike: "18"
Insert: "19"

9. Page 14, line 26.
Strike: "7"
Insert: "8"
Strike: "20"
Insert: "21"

10. Page 14, line 27.
Strike: "22"
Insert: "23"
Strike: "24"
Insert: "25"

11. Page 14, line 28.
Strike: "8"
Insert: "9"
Strike: "19"
Insert: "20"

12. Page 14, line 30.
Following: "1"
Insert: ", 2(4), and 3"
Strike: "7"
Insert: "8"

-END-

HOUSE BILL NO. 511

INTRODUCED BY R. JOHNSON

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE HEALTH CARE ADVISORY COUNCIL; PROVIDING FOR MEMBERSHIP, MEETINGS, COORDINATION, AND STAFF SUPPORT; PROVIDING FOR A TRANSITIONAL MEETING BETWEEN THE HEALTH CARE ADVISORY COUNCIL AND THE MONTANA HEALTH CARE AUTHORITY; MAINTAINING THE RESPONSIBILITY OF THE STATE HEALTH PLAN WITH THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES; ELIMINATING THE MONTANA HEALTH CARE AUTHORITY; TRANSFERRING THE RESPONSIBILITY FOR THE HEALTH CARE DATA BASE TO THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES; TRANSFERRING THE RESPONSIBILITY FOR CERTIFICATES OF PUBLIC ADVANTAGE TO THE DEPARTMENT OF JUSTICE; AMENDING SECTIONS 33-22-1809 ~~AND 50-1-201~~, 50-4-502, 50-4-601, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612, MCA; REPEALING SECTIONS 50-1-201, 50-4-101, 50-4-102, 50-4-201, 50-4-202, 50-4-301, 50-4-302, 50-4-303, 50-4-304, 50-4-305, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, 50-4-401, 50-4-402, 50-4-501, ~~50-4-502,~~ AND 50-4-503, ~~50-4-601, 50-4-602, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612,~~ MCA, AND SECTION 21, CHAPTER 606, LAWS OF 1993; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE."

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

NEW SECTION. **Section 1. Purpose.** (1) ~~The people of Montana have evaluated and rejected both the single-payer and multiple-payer health care reform plans developed by the Montana health care authority. However,~~ THE LEGISLATURE AND the public ~~has also~~ HAVE recognized the continued need for evaluation and analysis of Montana's health care system. The LEGISLATURE AND THE public ~~supports~~ SUPPORT an incremental private-sector approach to health care reform with an emphasis on affordability and on access to health care. The health care advisory council is created to continue the public-private partnership in order to develop initiatives regarding health care reform to be presented to the 1997 legislature.

(2) The health care advisory council shall monitor and evaluate implementation of recent health care reform initiatives, including small group insurance reform, the development of medicaid managed care, tort

reform, changes to the antitrust statutes, voluntary purchasing pools, and the efficiency of the certificate of need process. The health care advisory council shall provide reports on the progress of these reforms to the general public and to the legislature.

NEW SECTION. **SECTION 2. STATE HEALTH CARE POLICY.** (1) IT IS THE POLICY OF THE STATE OF MONTANA TO CONTINUE TO INVESTIGATE AND DEVELOP STRATEGIES THAT RESULT IN ALL RESIDENTS HAVING ACCESS TO QUALITY HEALTH SERVICES AT COSTS THAT ARE AFFORDABLE.

(2) IT IS FURTHER THE POLICY OF THE STATE OF MONTANA THAT:

(A) MONTANA'S HEALTH CARE SYSTEM SHOULD ENSURE THAT CARE IS DELIVERED IN THE MOST EFFECTIVE AND EFFICIENT MANNER POSSIBLE;

(B) HEALTH PROMOTION, PREVENTATIVE HEALTH SERVICES, AND PUBLIC HEALTH SERVICES SHOULD PLAY A CENTRAL ROLE IN THE SYSTEM;

(C) THE PATIENT-PROVIDER RELATIONSHIP SHOULD BE A FUNDAMENTAL COMPONENT OF MONTANA'S HEALTH CARE SYSTEM;

(D) INDIVIDUALS SHOULD BE ENCOURAGED TO PLAY A SIGNIFICANT ROLE IN DETERMINING THEIR HEALTH AND APPROPRIATE USE OF THE HEALTH CARE SYSTEM;

(E) ACCURATE AND TIMELY HEALTH CARE INFORMATION SHOULD PLAY A SIGNIFICANT ROLE IN DETERMINING THE INDIVIDUAL'S HEALTH AND APPROPRIATE USE OF THE HEALTH CARE SYSTEM;

(F) WHENEVER POSSIBLE, MARKET-BASED APPROACHES SHOULD BE RELIED ON TO CONTAIN THE GROWTH IN HEALTH CARE SPENDING WHILE ATTEMPTING TO ACHIEVE EXPANDED ACCESS, COST CONTAINMENT, AND IMPROVED QUALITY; AND

(G) THE PROCESS OF HEALTH CARE REFORM IN MONTANA SHOULD BE CARRIED OUT GRADUALLY AND SEQUENTIALLY TO ENSURE THAT ANY UNDESIRABLE IMPACTS OF THE STATE'S REFORM POLICIES ON OTHER ASPECTS OF THE STATE'S ECONOMY, PARTICULARLY ON SMALL BUSINESSES, ARE MINIMIZED.

(3) THE LEGISLATURE RECOGNIZES THE NEED TO INCREASE THE 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 THOSE SERVICES TO THE CONSUMER THAT ARE REASONABLE AND NECESSARY.

(4) [SECTIONS 1 THROUGH 7] MAY NOT BE INTERPRETED TO PREVENT MONTANA RESIDENTS FROM SEEKING HEALTH CARE SERVICES NOT OTHERWISE RECOMMENDED OR PROVIDED FOR AS A RESULT OF THE PROVISIONS OF [SECTIONS 1 THROUGH 7].

NEW SECTION. **Section 3. Health care advisory council.** (1) There is a health care advisory council.

(2) The health care advisory council is composed of 10 members. The members must be selected by May 1, 1995.

(a) There are four legislative members. Two members must be selected by the president of the senate from a pool of applicants from the senate, one representing each party. Two members must be selected by the speaker of the house from a pool of applicants from the house of representatives, one representing each party.

(b) There are five members, each representing a health care planning region as provided in [section 6], selected by the governor from a pool of applicants.

(c) There is one member representing the executive branch of government, appointed by the governor.

(3) Legislators and ~~regional board~~ members WHO REPRESENT HEALTH CARE PLANNING REGIONS AND who want to serve on the health care advisory council shall apply to the president of the senate, speaker of the house, or governor, respectively, for a position on the council. The application must include:

(a) a statement of the reason that the person wishes to serve on the council;

(b) the experience that qualifies the person to serve; and

(c) a statement of the person's willingness to commit the substantial time required to serve on the council.

(4) The members of the health care advisory council shall elect a presiding officer from among the members.

(5) A vacancy on the health care advisory council must be filled in the same manner as the original appointment.

NEW SECTION. **Section 4. Meetings.** (1) The health care advisory council may meet up to 10 times over the biennium.

(2) The council shall adopt rules of procedure for the conduct of the meetings.

NEW SECTION. **Section 5. Reimbursement of expenses -- compensation.** (1) ~~The~~ A member of the health care advisory council who is appointed by the governor is entitled to reimbursement for expenses as provided in 2-18-501 through 2-18-503.

(2) A legislative member is entitled to compensation and expenses as provided in 5-2-302.

NEW SECTION. **Section 6. Powers and duties -- report -- staff support.** (1) The health care advisory council shall study the considerations outlined in [section 1] and shall continue the study of solutions to the health care crisis and study methods of cost reduction in health care services and health care delivery systems.

(2) The health care advisory council shall report its findings to the governor and the legislature by October 1, 1996.

(3) The health care advisory council is the repository of all documents and materials of the Montana health care authority.

(4) The department of social and rehabilitation services shall provide staff support to the health care advisory council.

(5) The health care advisory council is attached to the department of social and rehabilitation services for administrative purposes only as provided in 2-15-121.

(6) The department of social and rehabilitation services, the department of health and environmental sciences, the commissioner of insurance, and the attorney general shall provide information to the health care advisory council as necessary.

NEW SECTION. Section 7. **Health care planning regions.** For the purpose of determining members of the health care advisory council, there are five health care planning regions that consist of the following counties:

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

(2) region II: Blaine, Hill, Liberty, Toole, Glacier, Phillips, Pondera, Teton, Chouteau, and Cascade;

(3) region III: Judith Basin, Fergus, Petroleum, Musselshell, Golden Valley, Wheatland, Sweet

Grass, Stillwater, Yellowstone, Carbon, and Big Horn;

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

(5) region V: Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, and Ravalli.

NEW SECTION. **Section 8. Transition from Montana health care authority study.** (1) The members of the health care advisory council and the members of the Montana health care authority shall hold one meeting before June 30, 1995. The meeting must be staffed by the Montana health care authority and the department of social and rehabilitation services.

(2) On or before June 30, 1995, the documents and materials compiled by the Montana health care authority must be transferred to the health care advisory council.

Section 9. Section 33-22-1809, MCA, is amended to read:

"**33-22-1809. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans under this part 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 50-4-201 certifies to the commissioner that the cost containment goal set forth in 50-4-303 is met on or before January 1, 1998, 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) 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.

(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 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.

(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.

(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.

(i) The commissioner 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 this part, 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 this part 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 this part 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."

~~**Section 9.** Section 50-1-201, MCA, is amended to read:~~

~~"**50-1-201. (Temporary) Administration of state health plan.** The department is hereby established as the sole and official state agency to administer the state program for comprehensive health planning and is hereby authorized to may prepare a plan for comprehensive state health planning. The department 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, 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 may accept, receive, expend, and administer any and all funds which that 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.~~

~~**50-1-201. (Effective July 1, 1996) Administration of state health plan.** The Montana health care authority created in 50-4-201 is the state agency to administer the state program for comprehensive health planning and shall prepare a plan for comprehensive state health planning. The authority may confer and cooperate with other persons, organizations, or governmental agencies that have an interest in public health problems and needs. The authority, while acting in this capacity as the state agency to administer and supervise the administration of the official comprehensive state health plan, is designated and authorized as the state agency to accept, receive, expend, and administer funds donated, granted, bequeathed, or appropriated to it for the preparation, administration, and supervision of the preparation and administration of the comprehensive state health plan."~~

SECTION 10. SECTION 50-4-502, MCA, IS AMENDED TO READ:

"**50-4-502. Health care data base -- information submitted ~~-- enforcement~~.** (1) The ~~authority~~ department, with advice from the health care advisory council, shall design and 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~~ that includes data on health care resources and the cost and quality of health care services. The purpose of the data base is to assist in developing and monitoring the progress of incremental health care reform measures that increase access to health care services, promote cost containment, and maintain quality of care.

(2) The ~~authority~~ department shall ~~by rule require~~ work in conjunction with 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~~ determine the information 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)~~(3) The ~~authority~~ department 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.

(4) The department shall make recommendations to the legislature by October 1, 1996, on the actions needed to establish the data base, including an estimate of the fiscal impact on state and local government, health care providers, health insurers, health care facilities, and private entities."

NEW SECTION. **SECTION 11. DEFINITIONS.** AS USED IN THIS PART, THE FOLLOWING DEFINITIONS APPLY:

(1) "DATA BASE" MEANS THE HEALTH CARE DATA BASE CREATED PURSUANT TO 50-4-502.

(2) "DEPARTMENT" MEANS THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES PROVIDED FOR IN TITLE 2, CHAPTER 15, PART 22.

(3) "HEALTH CARE" INCLUDES BOTH PHYSICAL HEALTH CARE AND MENTAL HEALTH CARE.

(4) "HEALTH CARE ADVISORY COUNCIL" MEANS THE COUNCIL PROVIDED FOR IN [SECTIONS 1 THROUGH ~~6~~ 7].

(5) "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.

(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) "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.

SECTION 12. SECTION 50-4-601, MCA, IS AMENDED TO READ:

"**50-4-601. 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 this part is to provide the state, through the ~~authority~~ department, 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."

SECTION 13. SECTION 50-4-603, MCA, IS AMENDED TO READ:

"**50-4-603. Certificate of public advantage -- standards for certification -- time for action by ~~authority~~ department.** (1) Parties to a cooperative agreement may apply to the ~~authority~~ department 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~~ department shall hold a public hearing on the application for a certificate before acting upon the application. The ~~authority~~ department may not issue a certificate unless the ~~authority~~ department 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~~ department denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the ~~authority~~ department not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

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

SECTION 14. SECTION 50-4-604, MCA, IS AMENDED TO READ:

"**50-4-604. Reconsideration by ~~authority~~ department.** (1) If the ~~authority~~ department denies an application and refuses to issue a certificate, a party to the agreement may request that the ~~authority~~ department reconsider its decision. The ~~authority~~ department shall reconsider its decision if the party applying for reconsideration submits the request to the ~~authority~~ department in writing within 30 calendar days of the ~~authority's~~ department's decision to deny the initial application.

(2) The ~~authority~~ department 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~~ department 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~~ department 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."

SECTION 15. SECTION 50-4-609, MCA, IS AMENDED TO READ:

"**50-4-609. Revocation of certificate by ~~authority~~ department.** (1) The ~~authority~~ department shall revoke a certificate previously granted by it if the ~~authority~~ department 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~~ department without giving notice and an opportunity for a hearing before the ~~authority~~ department 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~~ department 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~~ department 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~~ department 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~~ department, the agreement for which the certificate was issued is terminated."

SECTION 16. SECTION 50-4-610, MCA, IS AMENDED TO READ:

"**50-4-610. 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~~ department to deny an application for a certificate or a decision by the ~~authority~~ department to revoke a certificate. A revocation of a certificate pursuant to 50-4-609 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."

SECTION 17. SECTION 50-4-611, MCA, IS AMENDED TO READ:

"**50-4-611. Record of agreements to be kept.** The ~~authority~~ department shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to this part. A party to a cooperative agreement who terminates the agreement shall notify the ~~authority~~ department in writing of the termination within 30 days after the termination."

SECTION 18. SECTION 50-4-612, MCA, IS AMENDED TO READ:

"**50-4-612. Rulemaking.** The ~~authority~~ department shall adopt rules to implement this part. 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 this part, and appeals; and

(3) to effect the active supervision by the ~~authority~~ department 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 19. DEFINITIONS.** FOR THE PURPOSES OF THIS PART, THE FOLLOWING DEFINITIONS APPLY:

(1) "CERTIFICATE OF PUBLIC ADVANTAGE" OR "CERTIFICATE" MEANS A WRITTEN CERTIFICATE ISSUED BY THE DEPARTMENT AS EVIDENCE OF THE DEPARTMENT'S INTENTION THAT THE IMPLEMENTATION OF A COOPERATIVE AGREEMENT, WHEN ACTIVELY SUPERVISED BY THE DEPARTMENT, RECEIVE STATE ACTION IMMUNITY FROM PROSECUTION AS A VIOLATION OF STATE OR FEDERAL ANTITRUST LAWS.

(2) "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) "DEPARTMENT" MEANS THE DEPARTMENT OF JUSTICE PROVIDED FOR IN TITLE 2, CHAPTER 15, PART 20.

(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.

NEW SECTION. **Section 20. Repealer.** Sections 50-1-201, 50-4-101, 50-4-102, 50-4-201, 50-4-202, 50-4-301, 50-4-302, 50-4-303, 50-4-304, 50-4-305, 50-4-306, 50-4-307, 50-4-308, 50-4-309, 50-4-310, 50-4-311, 50-4-401, 50-4-402, 50-4-501, ~~50-4-502,~~ AND 50-4-503, ~~50-4-601, 50-4-602, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, and 50-4-612,~~ MCA, and section 21, Chapter 606, Laws of 1993, are repealed.

NEW SECTION. **SECTION 21. NAME CHANGE -- DIRECTIONS TO CODE COMMISSIONER.** WHEREVER THE NAME OF OR A REFERENCE TO THE MONTANA HEALTH CARE AUTHORITY APPEARS IN LEGISLATION ENACTED BY THE 1995 LEGISLATURE TO BE CODIFIED IN TITLE 50, CHAPTER 4, PART 6, THE CODE COMMISSIONER IS DIRECTED TO CHANGE THE REFERENCE TO THE DEPARTMENT OF JUSTICE.

NEW SECTION. **Section 22. Codification ~~instruction.~~ INSTRUCTIONS.** (1) [Sections 1 through ~~6~~ 7] are intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [sections 1 through ~~6~~ 7].

(2) [SECTION ~~10~~ 11] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 50, CHAPTER 4, PART 5, AND THE PROVISIONS OF TITLE 50, CHAPTER 4, PART 5, APPLY TO [SECTION ~~10~~ 11].

(3) [SECTION ~~18~~ 19] IS INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 50, CHAPTER 4, PART 6, AND THE PROVISIONS OF TITLE 50, CHAPTER 4, PART 6, APPLY TO [SECTION ~~18~~ 19].

NEW SECTION. **Section 23. Coordination instruction.** If ___ Bill No. ____ [LC 935] is passed and approved, then the department of public health and human services shall provide staff support to the health care advisory council and the council must be administratively attached to the department of public health and human services as provided in 2-15-121.

NEW SECTION. **Section 24. Effective dates.** (1) [Sections 1 through ~~7~~ 8, ~~11, 12, and 14~~ ~~20~~ 21 THROUGH ~~22~~ 23, AND ~~24~~ 25 and this section] are effective on passage and approval.

(2) [Sections ~~8~~ 9 through ~~10~~ ~~18~~ 20] are effective July 1, 1995.

NEW SECTION. **Section 25. Termination.** [Sections 1, 2(4), AND 3 through ~~7~~ 8] terminate June 30, 1997.

-END-