SENATE BILL NO. 177

INTRODUCED BY Foster

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING INSURANCE PRODUCERS AND HEALTH MAINTENANCE ORGANIZATIONS TO DISCLOSE THE MEANING OF CERTAIN TERMS AND PROVIDE AN EXPLANATION OF CHARGES; AND AMENDING SECTION 33-31-301, MCA."

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

NEW SECTION. **Section 1. Explanation of charges.** (1) A policy, subscriber contract, or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, prevailing fee, allowable charges, or relative value schedule and that is issued or issued for delivery in this state or renewed, extended, or modified on or after October 1, 1995, must include in plain language an explanation of:

(a) how the insurance producer calculates the amounts that it determines to be usual and customary, reasonable and customary, prevailing fee, allowable charges, or relative value schedule;

(b) the sources of data used to make the determinations in subsection (1)(a);

(c) the size and location of the geographic area considered in making the determination in subsection (1)(a);

(d) the possible balance of charges to be paid by the insured; and

(e) how the insurance producer determines that a provider's charges are unreasonable.

(2) An insurance producer shall provide to the policyholder and to the health care provider, as defined in 33-9-101, the same explanation required in subsections (1)(a) through 1(e) when claims are processed.

Section 2. Section 33-31-301, MCA, is amended to read:

"33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) ~~Every~~ Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or

otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider~~,~~ if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area;

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or ~~his~~ the enrollee's dependents;

(f) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for ~~such~~ treatment and referral services, the enrollee's designated provider ~~must~~ shall limit ~~his~~ treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee~~,~~ or ~~his~~ the enrollee's dependents~~,~~ or family members continuing coverage on the enrollee, ~~his~~ dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, ~~his~~ or the enrollee's dependents~~,~~ or family members covered under the evidence of coverage ceases because of termination of employment, ~~or~~ because of ~~his~~ the enrollee's membership in the class or classes eligible for coverage under the policy, or because ~~his~~ the enrollee's employer discontinues ~~his~~ business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services~~.~~;

(j) definitions for terms that limit payment of health care services based on standards described as usual and customary, reasonable and customary, prevailing fee, allowable charges, or a relative value schedule and an explanation of the charges as provided in [section 1].

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or ~~his~~ the enrollee's dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee ~~must~~ may not be individually determined based on the status of ~~his~~ the enrollee's health.

(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. ~~If the~~ The commissioner ~~disapproves the filing, he~~ shall notify the filer of a disapproved filing. In the notice, the commissioner shall specify the reasons for ~~his~~ disapproval. The commissioner shall grant a hearing within 30 days after ~~he receives~~ receiving a written request by the filer.

(8) The commissioner may ~~in his discretion~~ require a health maintenance organization to submit any ~~relevant~~ information ~~he considers necessary in~~ relevant to determining whether to approve or disapprove a filing made pursuant to this section."

NEW SECTION. **Section 3. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 15, and the provisions of Title 33, chapter 15, apply to [section 1].

-END-

APPROVED BY COM ON
BUSINESS & INDUSTRY

SENATE BILL NO. 177

INTRODUCED BY FOSTER

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~~(a) how the insurance producer calculates the amounts that it determines to be usual and customary, reasonable and customary, prevailing fee, allowable charges, or relative value schedule;~~

~~(b) the sources of data used to make the determinations in subsection (1)(a);~~

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~~(2) An insurance producer shall provide to the policyholder and to the health care provider, as defined in 33-9-101, the same explanation required in subsections (1)(a) through 1(e) when claims are processed~~ A DISABILITY INSURER, HEALTH SERVICE CORPORATION, OR HEALTH MAINTENANCE ORGANIZATION THAT ISSUES POLICIES, CERTIFICATES, OR CONTRACTS, THAT ISSUES POLICIES, CERTIFICATES, OR CONTRACTS FOR DELIVERY IN THIS STATE, OR THAT RENEWS, EXTENDS, OR MODIFIES POLICIES, CERTIFICATES, OR CONTRACTS ON OR AFTER OCTOBER 1, 1995, SHALL INCLUDE IN THE DISABILITY POLICIES, CERTIFICATES, OR CONTRACTS DEFINITIONS FOR TERMS THAT LIMIT PAYMENT OF HEALTH CARE SERVICES BASED ON STANDARDS DESCRIBED AS USUAL AND

CUSTOMARY, REASONABLE AND CUSTOMARY, PREVAILING FEE, ALLOWABLE CHARGES, OR A RELATIVE VALUE SCHEDULE.

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NEW SECTION. **Section 2. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 15, and the provisions of Title 33, chapter 15, apply to [section 1].

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-END-

HOUSE COMMITTEE OF THE WHOLE AMENDMENT

Senate Bill 177
Representative Ellingson

March 4, 1995 10:48 am

Mr. Chairman: I move to amend **Senate Bill 177** (third reading copy -- blue).

Signed: Jim Ellingson
Representative Ellingson

And, that such amendments to Senate Bill 177 read as follows:

1. Page 2, line 2.
Following: "."
Insert: "These definitions must inform the insured that the insured's health care provider may charge more than the limits established by the defined terms and that such additional charges may not be covered by the policy, certificate, or contract."

-END-

SB 177

ADOPT 78-1

REJECT

HOUSE

511047CW.Hbk

SENATE BILL NO. 177

INTRODUCED BY FOSTER

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING ~~INSURANCE PRODUCERS~~ DISABILITY INSURERS, HEALTH SERVICE CORPORATIONS, AND HEALTH MAINTENANCE ORGANIZATIONS TO DISCLOSE THE MEANING OF CERTAIN TERMS ~~AND PROVIDE AN EXPLANATION OF CHARGES; AND AMENDING SECTION 33-31-301, MCA~~."

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

NEW SECTION. **Section 1. Explanation of charges.** ~~(1) A policy, subscriber contract, or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, prevailing fee, allowable charges, or relative value schedule and that is issued or issued for delivery in this state or renewed, extended, or modified on or after October 1, 1995, must include in plain language an explanation of:~~

~~(a) how the insurance producer calculates the amounts that it determines to be usual and customary, reasonable and customary, prevailing fee, allowable charges, or relative value schedule;~~

~~(b) the sources of data used to make the determinations in subsection (1)(a);~~

~~(c) the size and location of the geographic area considered in making the determination in subsection (1)(a);~~

~~(d) the possible balance of charges to be paid by the insured; and~~

~~(e) how the insurance producer determines that a provider's charges are unreasonable.~~

~~(2) An insurance producer shall provide to the policyholder and to the health care provider, as defined in 33-9-101, the same explanation required in subsections (1)(a) through 1(e) when claims are processed~~ A DISABILITY INSURER, HEALTH SERVICE CORPORATION, OR HEALTH MAINTENANCE ORGANIZATION THAT ISSUES POLICIES, CERTIFICATES, OR CONTRACTS, THAT ISSUES POLICIES, CERTIFICATES, OR CONTRACTS FOR DELIVERY IN THIS STATE, OR THAT RENEWS, EXTENDS, OR MODIFIES POLICIES, CERTIFICATES, OR CONTRACTS ON OR AFTER OCTOBER 1, 1995, SHALL INCLUDE IN THE DISABILITY POLICIES, CERTIFICATES, OR CONTRACTS DEFINITIONS FOR TERMS THAT LIMIT PAYMENT OF HEALTH CARE SERVICES BASED ON STANDARDS DESCRIBED AS USUAL AND

CUSTOMARY, REASONABLE AND CUSTOMARY, PREVAILING FEE, ALLOWABLE CHARGES, OR A RELATIVE VALUE SCHEDULE. THESE DEFINITIONS MUST INFORM THE INSURED THAT THE INSURED'S HEALTH CARE PROVIDER MAY CHARGE MORE THAN THE LIMITS ESTABLISHED BY THE DEFINED TERMS AND THAT SUCH ADDITIONAL CHARGES MAY NOT BE COVERED BY THE POLICY, CERTIFICATE, OR CONTRACT.

~~**Section 2.** Section 33-31-301, MCA, is amended to read:~~

~~"**33-31-301. Evidence of coverage -- schedule of charges for health care services.** (1) Every Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.~~

~~(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.~~

~~(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:~~

~~(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:~~

~~(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;~~

~~(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;~~

~~(iii) the location at which and the manner in which information is available as to how services may be obtained;~~

~~(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and~~

~~(v) a clear and understandable description of the health maintenance organization's method for~~

~~resolving enrollee complaints;~~

~~(b) definitions of geographical service area, emergency care, urgent care, out of area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.~~

~~(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:~~

~~(i) emergency and urgent care;~~

~~(ii) restrictions on the selection of primary or referral providers;~~

~~(iii) restrictions on changing providers during the contract period;~~

~~(iv) out of pocket costs, including copayments and deductibles;~~

~~(v) charges for missed appointments or other administrative sanctions;~~

~~(vi) restrictions on access to care if copayments or other charges are not paid; and~~

~~(vii) any restrictions on coverage for dependents who do not reside in the service area;~~

~~(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;~~

~~(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or his the enrollee's dependents;~~

~~(f) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:~~

~~(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;~~

~~(ii) if an enrollee chooses a provider other than the health maintenance organization provider for such treatment and referral services, the enrollee's designated provider must shall limit his treatment and~~

~~services to the scope of the referral in order to receive payment from the health maintenance organization;~~

~~(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;~~

~~(g) a provision as follows:~~

~~"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."~~

~~(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, or his the enrollee's dependents, or family members continuing coverage on the enrollee, his dependents, or family members:~~

~~(i) if the evidence of coverage or any portion of it on an enrollee, his or the enrollee's dependents, or family members covered under the evidence of coverage ceases because of termination of employment, or because of his the enrollee's membership in the class or classes eligible for coverage under the policy, or because his the enrollee's employer discontinues his business or the coverage;~~

~~(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and~~

~~(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.~~

~~(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.;~~

~~(j) definitions for terms that limit payment of health care services based on standards described as usual and customary, reasonable and customary, prevailing fee, allowable charges, or a relative value schedule and an explanation of the charges as provided in [section 1].~~

~~(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.~~

~~(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants there may be no~~

~~waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.~~

~~(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or his the enrollee's dependents from and after the moment of birth.~~

~~(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.~~

~~(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee must may not be individually determined based on the status of his the enrollee's health.~~

~~(7) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the The commissioner disapproves the filing, he shall notify the filer of a disapproved filing. In the notice, the commissioner shall specify the reasons for his disapproval. The commissioner shall grant a hearing within 30 days after he receives receiving a written request by the filer.~~

~~(8) The commissioner may in his discretion require a health maintenance organization to submit any relevant information he considers necessary in relevant to determining whether to approve or disapprove a filing made pursuant to this section."~~

NEW SECTION. **Section 2. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 15, and the provisions of Title 33, chapter 15, apply to [section 1].

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