_____ BILL NO. _____

INTRODUCED BY _____

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING UNFAIR TRADE PRACTICES AND CONSUMER PROTECTIONS IN HEALTH CARE CONTRACTS; PROVIDING FOR LIMITATIONS ON ANTICOMPETITIVE HEALTH CARE CONTRACT TERMS; PROVIDING FOR A WAIVER; PROVIDING FOR ENFORCEMENT AUTHORITY BY THE DEPARTMENT OF JUSTICE AND BY THE INSURANCE COMMISSIONER; PROVIDING RULEMAKING AUTHORITY; PROVIDING DEFINITIONS; AMENDING SECTION 28-2-724, MCA; AND PROVIDING AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Definitions.** As used in [sections 1 through 8], unless the context clearly indicates otherwise, the following definitions apply:

(1) "All-or-nothing clause" means a provision of a health care contract that:

(a) requires the health carrier or health plan administrator to include all members of a health care provider in a network plan; or

(b) requires the health carrier or health plan administrator to enter into any additional contracts with an affiliate of the health care provider as a condition of entering into a contract with the health care provider.

(2) "All-products clause" means a provision in a health care contract that requires a health care provider, as a condition of participation or continuation in a provider network or a health benefit plan, to:

(a) serve in another provider network utilized by a health carrier, subcontractor, or affiliate with different reimbursement rates and other financial terms for the health care provider; or

(b) provide health care services under another health benefit plan or product offered by a health carrier, subcontractor, or affiliate with different reimbursement rates and other financial terms for the health care provider.

(3) "Anti-steering clause" means a provision of a health care contract that restricts the ability of the health carrier or health plan administrator to encourage an enrollee to obtain a health care service from a

competitor of the hospital or health system, including offering incentives to encourage enrollees to utilize specific health care providers.

(4) "Anti-tiering clause" means a provision in a health care contract that:

(a) restricts the ability of the health carrier or health plan administrator to introduce or modify a tiered network plan or assign health care providers into tiers; or

(b) requires the health carrier or health plan administrator to place all members of a health care provider in the same tier of a tiered network plan.

(5) "Commissioner" means the commissioner of insurance of the state of Montana.

(6) "Department" means the department of justice provided for in 2-15-2001.

(7) "Enrollee" has the same meaning as provided in 33-1-801.

(8) "Gag clause" means a provision of a health care contract that:

(a) restricts the ability of the health carrier, the health plan administrator, or the provider to disclose any price or quality information, including the allowed amount, negotiated rates or discounts, any fees for services, or any other claim-related financial obligations included in the provider contract, to a government entity as authorized by law or its contractors or agents or any enrollee, treating provider of an enrollee, plan sponsor, or potential eligible enrollees and plan sponsors; or

(b) restricts the ability of the health carrier, the health plan administrator, or the provider, including a pharmacist, to disclose out-of-pocket costs or that restricts a provider or pharmacist from disclosing lower cost options to an enrollee.

(9) "Health benefit plan" means a policy, contract, certificate, or agreement that is entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including medical care, dental care, and vision care.

(10) "Health care contract" means a contract, agreement, or understanding, either orally or in writing, that is entered into, amended, restated, or renewed between a health care provider and a health carrier, health plan administrator, or plan sponsor, or its contractors or agents, for the delivery of health care services to an enrollee of a health benefit plan.

(11) "Health care provider" means an entity, corporation, or organization or a parent corporation, member, affiliate, subsidiary, or entity under common ownership, whether for profit or nonprofit, that is or whose

members are licensed or otherwise authorized by the state to furnish, bill, or receive payment for health care service delivery in the normal course of business. The term includes, without limitation, health systems, hospitals, hospital-based facilities, freestanding emergency facilities, imaging centers, large physician groups with eight or more physicians, physician staffing organizations, and urgent care clinics.

(12) "Health carrier" has the same meaning as provided in 33-1-801.

(13) "Health plan administrator" means a third-party administrator who acts on behalf of a plan sponsor to administer a health benefit plan.

(14) "Most-favored-nations clause" means a provision of a health care contract that:

(a) prohibits or grants a health carrier or health plan administrator an option to prohibit a participating health care provider from contracting with another contracting entity to provide health care services at the same or lower price than the payment specified in the health care contract;

(b) requires or grants a health carrier or health plan administrator an option to require a participating health care provider to accept a lower payment in the event the participating health care provider agrees to provide health care services to another contracting entity at a lower price;

(c) requires or grants a health carrier or health plan administrator an option to require termination or renegotiation of an existing health care contract if a participating health care provider agrees to provide health care services to another contracting entity at the same or lower price; or

(d) restricts other health carriers or health plan administrators not party to the contract from paying the same or lower rates for items or services than the contracting health carrier or health plan administrator pays for such items or services.

(15) "Network plan" means a health benefit plan that either requires enrollees to use or creates incentives, including financial incentives, for enrollees to use certain health care providers managed, owned, affiliated, under contract with, or employed by a health carrier, a health plan administrator, or a plan sponsor. Network plans include health maintenance organization plans, preferred provider organization plans, and exclusive provider organization plans.

(16) "Tiered network plan" means a health benefit plan that sorts some or all types of health care providers into specific groups to which different provider reimbursement, enrollee cost sharing, or provider access requirements, or any combination of those, are applied for the same services.

NEW SECTION. **Section 2. Limitations on anticompetitive health care contract terms.** (1) Except as provided in [section 3], a health carrier, a health care provider, a health plan administrator, or an agent or other entity that contracts on behalf of a health care provider, health carrier, or health plan administrator may not offer, solicit, request, amend, renew, or enter into a health care contract that directly or indirectly includes any of the following provisions:

(a) a most-favored-nations clause;

(b) an anti-steering clause;

(c) an anti-tiering clause;

(d) an all-or-nothing clause;

(e) a gag clause;

(f) an all-products clause; or

(g) any other clause that results or intends to result in anticompetitive effects as specified by the department through administrative rule.

(2) Except as provided in [section 3], a violation of [sections 1 through 8] constitutes an unfair or deceptive act under 30-14-103 and is presumptively unlawful, subject to enforcement by the department.

(3) A prohibition on all-products clauses does not prevent a contracting entity from:

(a) offering a health care provider a contract that covers multiple health benefit plans that have the same reimbursement rates and other financial terms for the health care provider;

(b) adding a new health benefit plan to an existing health care contract with a health care provider under the same reimbursement rates and other financial terms applicable under the original health care contract;

(c) requiring a health care provider to accept multiple health benefit plans that do not differ in reimbursement rates or other financial terms for the health care provider; or

(d) offering a health care provider a contract for another health benefit plan with different reimbursement rates or financial terms as long as participation in one plan is not conditional on participation in the other plan.

(4) A health care contract may include health benefit plans or coverage options for enrollees within

a health benefit plan with different cost-sharing structures, including different deductibles or copayments, as long as the reimbursement rates and other financial terms between the contracting entity and the health care provider remain the same for each plan or coverage option included in the health care contract.

NEW SECTION. **Section 3. Application for waiver -- severability.** (1) A party to a health care contract that contains a provision specified in [section 2(1)] may submit the health care contract to the department for a waiver. The health care contract must be accompanied by the following information:

(a) the name and business address of each party to the health care contract;

(b) an identification of each location at which any party to the agreement or policy provides health care services; and

(c) any information required to demonstrate that the proposed agreement or policy results in an increase in the welfare of consumers in the state that could not have been accomplished through alternative means that are less restrictive.

(2) The department shall approve or deny a waiver application in writing within 60 days of receiving the application.

(3) The department may approve a waiver to allow a contract to include a provision specified in [section 2(1)] only if the department determines:

(a) the agreement or policy will result in an increase in the welfare of consumers in the state in a way that ensures the procompetitive justifications of including the provision outweigh the harms to competition;

(b) an increase in the welfare of consumers in the state could not have been accomplished through alternative means that are less restrictive; and

(c) the agreement or policy does not otherwise constitute a contract, combination, or conspiracy in restraint of trade under state or federal antitrust laws.

(4) Except for contracts granted a waiver under this section by the department, any provision of a health care contract described in [section 2(1)] that violates [sections 1 through 8] is null and void and unenforceable. The remaining provisions of the health care contract, excluding any provision in violation of [sections 1 through 8], remain in effect and are enforceable.

NEW SECTION. **Section 4. Enforcement by department -- penalties -- equitable relief.** (1) The department may use authority granted to it by Title 30, chapter 14, part 1, to enforce any provision of [sections 1 through 8] or to investigate suspected violations of any provision of [sections 1 through 8].

(2) The department may institute proceedings on behalf of the state or on behalf of the persons residing in the state for:

(a) injunctive relief under 30-14-111 to prevent and restrain a violation of any provision of this chapter including, without limitation, a temporary restraining order, preliminary injunction, or permanent injunction;

(b) civil penalties under 30-14-142 for violations of any provision of [sections 1 through 8]; and

(c) other equitable relief for violations of any provision of [sections 1 through 8] including, without limitation, disgorgement or restitution.

NEW SECTION. **Section 5. Enforcement by commissioner -- penalties -- referral to department.** (1) All records and papers of health carriers pertaining to health benefit plans or negotiations between the health carrier and a health care provider are subject to inspection by the commissioner or by an agent the commissioner designates for that purpose. The commissioner may require a health carrier to produce a list of all health care contracts, transactions, or pricing arrangements entered into within the preceding 12 months.

(2) Except for contracts granted a waiver under [section 3], the commissioner may impose an administrative penalty of up to $5,000 a day on a health carrier for each day that a contract in violation of [section 2] is in effect.

(3) As provided in 33-16-211, the commissioner may deny the sale of a health insurance plan for which the contract between the health carrier and any health care provider is in violation of [section 2].

(4) The commissioner may refer a health care contract subject to this section to the department to review for compliance with [sections 1 through 8]. The referral of a health care contract by the commissioner to the department does not constitute a violation of any confidentiality agreement between the health carrier and the commissioner that may exist under 33-16-203. The authority of the department to prosecute violations of antitrust or consumer protection requirements is not narrowed, abrogated, or otherwise altered by this section.

NEW SECTION. **Section 6. Private right of action.** A party that suffers a loss as a result of a violation of [sections 1 through 8] is entitled to initiate an action pursuant to Title 30, chapter 14, part 1, and seek all remedies, damages, costs, and fees available under 30-14-131.

NEW SECTION. **Section 7. Effect on privacy.** (1) Nothing in this section modifies, reduces, or eliminates the existing privacy protections and standards provided by reason of state and federal law, including the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the federal Genetic Information Nondiscrimination Act of 2008, Public Law 110-233, and required confidentiality provisions of the Americans with Disabilities Act of 1990, Public Law 101-336.

(2) Nothing in this section may be construed to limit network design or cost or quality initiatives by a group health plan, a health carrier, or administrators working on behalf of a plan sponsor, including accountable care organizations, exclusive provider organizations, networks that tier providers by cost or quality or steer enrollees to centers of excellence, or other pay-for-performance programs.

NEW SECTION. **Section 8. Rulemaking authority.** (1) The department may adopt rules to implement [sections 2 through 4].

(2) The commissioner may adopt rules to implement [section 5].

Section 9. Section 28-2-724, MCA, is amended to read:

"**28-2-724. Prohibition of contracts that restrict practice -- applicability -- exceptions.** (1) A contract that creates or establishes the terms of employment, a partnership, or any other form of professional relationship with a health care provider described in subsection (2)~~,~~ may not restrict the right of the health care provider to:

(a) practice or provide services for which the provider is licensed, in any geographic area and for any period, after the termination of the employment, partnership, or other form of professional relationship;

(b) treat, advise, consult with, or establish a provider-patient relationship with any current patient of the employer or with a patient affiliated with a partnership or other form of professional relationship; or

(c) solicit or seek to establish a provider-patient relationship with any current patient of the

employer or with a patient affiliated with a partnership or other form of professional relationship.

(2) The requirements of subsection (1) apply to contracts or agreements involving the following health care providers:

(a) ~~a psychiatrist or addiction medicine physician licensed under Title 37, chapter 3~~ a physician licensed under Title 37, chapter 3;

(b) a psychologist licensed under Title 37, chapter 17;

(c) a social worker licensed under Title 37, chapter ~~22~~ 39;

(d) a professional counselor licensed under Title 37, chapter ~~23~~ 39;

(e) an addiction counselor licensed under Title 37, chapter ~~35~~ 39;

(f) a marriage and family therapist licensed under Title 37, chapter 39; ~~37; and~~

(g) a behavioral health peer support specialist licensed under Title 37, chapter ~~38~~ 39; and

(h) a registered professional nurse or an advanced practice registered nurse licensed under Title 37, chapter 8.

(3) This section does not apply to a contract in connection with the sale and purchase of a practice."

NEW SECTION. **Section 10. Notification to tribal governments.** The secretary of state shall send a copy of [this act] to each federally recognized tribal government in Montana.

NEW SECTION. **Section 11. Codification instruction.** [Sections 1 through 8] are intended to be codified as an integral part of Title 30, chapter 14, and the provisions of Title 30, chapter 14, apply to [sections 1 through 8].

NEW SECTION. **Section 12. Applicability.** [This act] applies to contracts or policies issued or renewed on or after October 1, 2025.

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