HOUSE BILL NO. 758

INTRODUCED BY S. GIST, E. BUTTREY

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING INSURANCE LAW TO PROHIBIT BALANCE BILLING FOR OUT-OF-NETWORK EMERGENCIES; APPLYING TO HEALTH INSURANCE PLANS; REQUIRING AMBULANCE GROUND TRANSPORTATION SERVICES TO BE PAID BY THE INSURER AT CERTAIN IN-NETWORK RATES; ESTABLISHING RATES; PROVIDING RULEMAKING AUTHORITY; REQUIRING REPORTING TO THE COMMISSIONER OF INSURANCE; PROVIDING DEFINITIONS; AND AMENDING SECTIONS 2-18-704, 30-14-2602, 33-31-111, AND 33-35-306, MCA."

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

NEW SECTION. **Section 1. Balance billing prohibited -- out-of-network emergency -- rulemaking.** (1) With respect to a health benefit plan, the state employee group benefits plan, the Montana university system group benefits plan, or a medicare supplement insurance policy that provides coverage for ambulance care and transportation, the insurer shall indemnify directly the provider of the ambulance care and transportation.

(2) An ambulance service may not bill an enrollee for covered ground transportation services, including nonemergency transportation between health care facilities, if the enrollee has paid the in-network cost-sharing amount specified in the enrollee's health benefit plan.

(3) For ambulance ground transportation services covered by a health benefit plan, the insurer:

(a) may not impose an out-of-pocket maximum that exceeds $100 for in-network or out-of-network providers;

(b) shall apply any out-of-pocket costs toward an applicable deductible;

(c) may not impose a deductible, out-of-pocket maximum, copayment, or coinsurance requirement on services provided by out-of-network providers that exceeds the deductible, out-of-pocket maximum, copayment, or coinsurance requirement imposed on services provided by in-network providers; and

(d) shall provide an explanation of benefits to the enrollee that reflects the cost-sharing amount.

(4) Unless the health benefit plan and the ambulance service have a contracted rate, the health benefit plan must reimburse the ambulance service at the established local rate, or if an established local rate does not exist, in an amount no less than 400% of the medicare rate.

(5) The department shall create a database of established local rates for ambulance ground transportation services. The department shall ensure this database is accessible to the public.

(6) Ambulance services must submit a catalog of local ground transportation rates to the department annually and within 5 calendar days of a change to the rates.

(7) The provisions of this section apply to a self-funded group health plan, whether governed by or exempt from the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 et seq., as amended, only if the self-funded group health plan elects to participate in the provisions of this section by providing notice to the department in the form and manner described by the department by rule.

(8) The department shall make rules to implement the provisions described in this section.

(9) The department may impose civil penalties and take appropriate action as provided in Title 33, chapter 1.

(10) As used in this section:

(a) "Department" means the commissioner of securities and insurance, Montana state auditor.

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

(c) "Health benefit plan" has the same meaning as provided in 33-1-801.

(d) "Health care facility" means a facility that provides health care services directly to patients, including but not limited to a hospital, clinic, health care provider's office, health maintenance organization, diagnostic or treatment center, mental health facility, hospice, and nursing home.

(e) "In-network" means services performed by a provider or health care service contractor that has directly contracted with the insurer.

(f) "Out-of-network" means services performed by a provider or provider group that has not contracted or has indirectly contracted with the insurer or health care service contractor.

Section 2. Section 2-18-704, MCA, is amended to read:

"**2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must

contain provisions that permit:

(a) the member of a group who retires from active service under the appropriate retirement provisions of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19, chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered employment to remain a member of the group until the member becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, unless the member is a participant in another group plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost;

(b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible for equivalent insurance coverage as provided in subsection (1)(a);

(c) the surviving children of a member to remain members of the group as long as they are eligible for retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

(2) An insurance contract or plan issued under this part must contain the provisions of subsection (1) for remaining a member of the group and also must permit:

(a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);

(b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and

(c) continued membership in the group by anyone eligible under the provisions of this section, notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

(3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a member of the state's group plan until the legislator becomes eligible for medicare under the federal Health Insurance for the Aged Act if the legislator:

(i) terminates service in the legislature and is a vested member of a state retirement system provided by law; and

(ii) notifies the department of administration in writing within 90 days of the end of the legislator's legislative term.

(b) A former legislator may not remain a member of the group plan under the provisions of subsection (3)(a) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

(c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and subsequently terminates membership may not rejoin the group plan unless the person again serves as a legislator.

(4) (a) A state insurance contract or plan must contain provisions that permit continued membership in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's choice to continue membership in the group plan.

(b) A former judge may not remain a member of the group plan under the provisions of this subsection (4) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or

(iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act.

(c) A judge who remains a member of the group under the provisions of this subsection (4) and subsequently terminates membership may not rejoin the group plan unless the person again serves in a position covered by the state's group plan.

(5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the full premium for coverage and for that of the person's covered dependents.

(6) An insurance contract or plan issued under this part that provides for the dispensing of prescription drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

(a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty to the member; and

(b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

(7) An insurance contract or plan issued under this part must include coverage for:

(a) treatment of inborn errors of metabolism, as provided for in 33-22-131;

(b) therapies for Down syndrome, as provided in 33-22-139;

(c) treatment for children with hearing loss as provided in 33-22-128(1) and (2);

(d) fertility preservation services as required under 33-22-2103;

(e) the care and treatment of mental illness in accordance with the provisions of Title 33, chapter 22, part 7;

(f) telehealth services, as provided for in 33-22-138; and

(g) refills of prescription eyedrops as provided in 33-22-154.

(8) (a) An insurance contract or plan issued under this part that provides coverage for an individual in a member's family must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the contract or plan.

(b) Coverage for well-child care under subsection (8)(a) must include:

(i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(ii) routine immunizations according to the schedule for immunization recommended by the advisory committee on immunization practices of the U.S. department of health and human services.

(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit as provided for in this subsection (8).

(d) For purposes of this subsection (8):

(i) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(ii) "well-child care" means the services described in subsection (8)(b) and delivered by a physician or a health care professional supervised by a physician.

(9) Upon renewal, an insurance contract or plan issued under this part under which coverage of a dependent terminates at a specified age must continue to provide coverage for any dependent, as defined in the insurance contract or plan, until the dependent reaches 26 years of age. For insurance contracts or plans issued under this part, the premium charged for the additional coverage of a dependent, as defined in the insurance contract or plan, may be required to be paid by the insured and not by the employer.

(10) Prior to issuance of an insurance contract or plan under this part, written informational materials describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan member.

(11) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician and, in the case of a health maintenance organization, the primary care physician, in consultation with the patient to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

(12) The state employee group benefits plan and the Montana university system group benefits plan must comply with [section 1] relating to the billing of ambulance services.

~~(12)~~(13)(a) (i) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for medically necessary and prescribed outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes. At a minimum, the benefit must consist of:

(A) 20 visits of training and education in diabetes self-management provided in either an individual or group setting if the person has not received the training and education previously; and

(B) 12 visits of followup diabetes self-management training and education services in subsequent years for an insured who has previously received and exhausted the initial 20 visits of education.

(ii) For the purposes of this subsection ~~(12)(a)~~ (13)(a), the term "visit" refers to a period of 30

minutes.

(b) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes, injection aids, devices for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration, and glucagon emergency kits.

(c) Nothing in subsection ~~(12)(a)~~ (13)(a) or ~~(12)(b)~~ (13)(b) prohibits the state or the Montana university group benefit plans from providing a greater benefit or an alternative benefit of substantially equal value, in which case subsection ~~(12)(a)~~ (13)(a) or ~~(12)(b)~~ (13)(b), as appropriate, does not apply.

(d) Annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy.

(e) This subsection ~~(12)~~ (13) does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies offered by the state or the Montana university system as benefits to employees, retirees, and their dependents.

~~(13)~~(14)(a) Except as provided in subsection ~~(16)~~ (17), the state employee group benefit plans and the Montana university system group benefits plans that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer firefighter dies within the course and scope of employment. Except as provided in subsection ~~(13)~~ ~~(b)~~ (14)(b), the continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this section must provide for the same level of benefits as is available to other members of the group. Premiums charged to a spouse or dependent under this section must be the same as premiums charged to other similarly situated members of the group. Dependent special enrollment must be allowed under the terms of the insurance contract or plan. The provisions of this subsection ~~(13)~~ ~~(a)~~ (14)(a) are applicable to a spouse or dependent who is insured under a COBRA continuation provision.

(b) The state employee group benefit plans and the Montana university system group benefits plans subject to the provisions of subsection ~~(13)(a)~~ (14)(a) may discontinue or not renew the coverage of a

spouse or dependent only if:

(i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms of the state employee group benefit plans and the Montana university system group benefits plans or if the plans have not received timely premium payments;

(ii) the spouse or dependent has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage; or

(iii) the state employee group benefit plans and the Montana university system group benefits plans are ceasing to offer coverage in accordance with applicable state law.

~~(14)~~(15)The state employee group benefit plans and the Montana university system group benefits plans must comply with the provisions of 33-22-153.

~~(15)~~(16)An insurance contract or plan issued under this part and a group benefits plan issued by the Montana university system must provide mental health coverage that meets the provisions of Title 33, chapter 22, part 7.

~~(16)~~(17)The employing state agency of a law enforcement officer as defined in 2-15-2040 who is covered under the state employee group benefit plan shall:

(a) if the officer is catastrophically injured in the line of duty as defined in 2-15-2040, enroll the officer and the officer's covered spouse or dependent children in COBRA continuation coverage when that officer is terminated from employment as a result of the catastrophic injury. The officer and the officer's spouse or dependent children may opt out of COBRA continuation coverage within 60 days of enrollment.

(b) enroll the officer's covered spouse or dependent children in COBRA continuation coverage if the officer dies in the line of duty as defined in 2-15-2040. The officer's spouse or dependent children may opt out of COBRA coverage within 60 days of the date of enrollment.

(c) pay the COBRA premium for 4 months of COBRA continuation coverage for the officer and the officer's covered spouse or dependent children enrolled in COBRA continuation coverage pursuant to subsections ~~(16)(a)~~ (17)(a) or ~~(16)(b)~~ (17)(b), after which time the officer and the officer's spouse or dependent children shall pay the COBRA premium. (See compiler's comments for contingent termination of certain text.)"

Section 3. Section 30-14-2602, MCA, is amended to read:

"**30-14-2602. Balance billing information -- notification to ambulance companies.** (1) (a) Subject to one of the conditions under subsection (1)(b), an ambulance service licensed in this state may not submit to a consumer reporting agency information intended to affect a patient's credit report because the patient has not made full payment of a bill for ambulance services.

(b) The prohibition under subsection (1)(a) is effective if:

(i) the patient's insurer or health plan has paid for the ambulance services based on the in-network or out-of-network charges outlined in the patient's insurance plan if the insurer has otherwise complied with [section 1]; or

(ii) an uninsured patient has paid toward the bill and filed with the attorney general's office a complaint regarding the bill as being an unfair trade practice because the bill is not based on usual and customary charges in the state.

(2) An ambulance service that transfers a bill to a collection agency shall state that the collection agency may not report as delinquent to a consumer reporting agency a bill covered by subsection (1)."

Section 4. Section 33-31-111, MCA, is amended to read:

"**33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of

pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under Title 33, chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, parts 7 and 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Other chapters and provisions of this title apply to health maintenance organizations as follows: Title 33, chapter 1, parts 6, 12, and 13; 33-2-1114; 33-2-1211 and 33-2-1212; Title 33, chapter 2, parts 13, 19, 23, and 24; 33-3-401; 33-3-422; 33-3-431; Title 33, chapter 3, part 6; Title 33, chapter 10; Title 33, chapter 12; 33-15-308; Title 33, chapter 17; Title 33, chapter 19; 33-22-107; 33-22-114; 33-22-128; 33-22-129; 33-22-131; 33-22-136 through 33-22-139; 33-22-141 and 33-22-142; 33-22-152 through 33-22-159; 33-22-180; [section 1], 33-22-244; 33-22-246 and 33-22-247; 33-22-514 and 33-22-515; 33-22-521; 33-22-523 and 33-22-524; 33-22-526; 33-22-2103; and Title 33, chapter 32."

Section 5. Section 33-35-306, MCA, is amended to read:

"**33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(c) Title 33, chapter 1, part 7;

(d) Title 33, chapter 2, parts 23 and 24;

(e) 33-3-308;

(f) Title 33, chapter 7;

(g) Title 33, chapter 18, except 33-18-242;

(h) Title 33, chapter 19;

(i) 33-22-107, 33-22-114, 33-22-128, 33-22-129, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, ~~and~~ 33-22-152 through 33-22-155, and [section 1];

(j) 33-22-316;

(k) 33-22-512, 33-22-515, 33-22-525, and 33-22-526;

(l) Title 33, chapter 22, parts 7 and 21; and

(m) 33-22-707.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

NEW SECTION. **Section 6. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 1].

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