HOUSE BILL NO. 620

INTRODUCED BY A. REDFIELD

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING THE MONTANA ALL-PAYER CLAIMS DATABASE; PROVIDING HEALTH CARE CONSUMERS ACCESS TO DATA TO DETERMINE WHERE HEALTH CARE SERVICES ARE OFFERED AND THE COST OF THOSE SERVICES; ESTABLISHING REQUIREMENTS FOR SUBMISSION OF INFORMATION TO THE DATABASE; PROVIDING THE COMMISSIONER OF INSURANCE WITH OVERSIGHT RESPONSIBILITIES; REQUIRING THE PARTICIPATION OF HEALTH PLANS AND THIRD-PARTY ADMINISTRATORS; PROVIDING DEFINITIONS; PROVIDING RULEMAKING AUTHORITY; PROVIDING AN APPROPRIATION; AMENDING SECTIONS 2-18-702, 33-31-111, AND 33-35-306, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

NEW SECTION. **Section 1. Legislative findings -- intent.** (1) The legislature finds that the increasing cost of health care services to individual consumers, businesses, and state and local governments warrants the review and evaluation of information related to health care services and costs. The legislature further finds that this review is best accomplished by collecting and analyzing information on health care services that are provided to Montanans and on the payments made for those services. Analysis of this information will allow policymakers, health plans, health care providers, researchers, and consumers to make more informed decisions about controlling health care costs and to use available health care information to determine the quality of health care services.

(2) The intent of [sections 1 through 6] is to create the Montana all-payer claims database for the collection and analysis of health care information. The purpose of the database is to:

(a) provide transparency regarding health care pricing and the quality of health care services in order to promote competition and accountability among health plans and health care providers; and

(b) allow consumers to electronically access information about where health care services are provided and the actual cost of those services.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 6], the following definitions

apply:

(1) "Database" means the Montana all-payer claims database.

(2) (a) "Health plan" means:

(i) health insurance coverage or a group health plan as defined in 33-22-140 that is issued by a health insurance issuer as defined in 33-22-140 or that is administered by a third-party administrator;

(ii) a state or local government group benefits plan provided pursuant to Title 2, chapter 18; and

(iii) a self-funded multiple employer welfare arrangement provided for in Title 33, chapter 35.

(b) The term does not include excepted benefits as defined in 33-22-140.

NEW SECTION. **Section 3. Applicability.** [Sections 1 through 6] apply to:

(1) a health plan; and

(2) a third-party administrator that administers claims for a self-funded health plan and that is licensed under Title 33, chapter 17, part 6.

NEW SECTION. **Section 4. Powers and duties of commissioner -- rulemaking.** The commissioner shall:

(1) establish and oversee development and use of the database;

(2) establish criteria for the selection of a vendor, pursuant to the provisions of Title 18, chapter 4, to create and maintain the database;

(3) contract with a vendor to collect, store, and distribute data in accordance with administrative rules promulgated by the commissioner;

(4) promote the availability of information to payers, health plans, health care providers, consumers, and other interested parties in order to support transparency of the information;

(5) publish reports on trends and variances in cost and payment of health care services;

(6) conduct public education activities to raise awareness of the availability of health care cost information and other data maintained in the database;

(7) consult on a regular basis with parties interested in the database, including but not limited to health plans, health care providers, and consumers;

(8) adopt rules necessary to implement [sections 1 through 6], including but not limited to rules:

(a) ensuring the privacy and security of information in the database;

(b) assessing user fees; and

(c) for the submission of information to the database, including:

(i) the types of information and the format in which information must be submitted; and

(ii) other requirements necessary to maintain the database in a manner that promotes efficiency, eliminates unnecessary burdens on the providers and users of the data, and promotes to the fullest extent possible all uses of the data that support the purpose of the database;

(9) investigate and refer for further action, if appropriate, complaints received from the public related to the activities of the database vendor; and

(10) keep an accurate accounting of all expenditures related to the database. The commissioner shall annually submit to the governor and the legislature a report containing this accounting, including the relevant financial records of the database vendor.

NEW SECTION. **Section 5. All-payer claims database -- reporting -- penalty.** (1) (a) A health plan covering at least 5% of the lives covered by major medical health plans in Montana and a third-party administrator that administers claims for at least 5% of the lives covered under self-funded health plans and that is licensed under Title 33, chapter 17, part 6, shall submit to the commissioner for inclusion in the database:

(i) claims information, including the amounts paid on the claims; and

(ii) other information determined by the commissioner to be necessary to accomplish the purposes of the database as established in [sections 1 through 6] and in administrative rule.

(b) Information must be submitted at the time the database becomes operational.

(2) To the greatest extent possible, the commissioner shall arrange for the collection of claims information from the federal employee health benefit plans and the Indian health service.

(3) Claims information submitted to the database is subject to all state and federal laws governing privacy of health care information and of trade secrets.

(4) A health plan or third-party administrator that fails to comply with the requirements of this section is subject to a fine of up to $5,000 per violation and may be prohibited from obtaining information maintained in the database.

(5) Fines collected under this section must be deposited in a state special revenue account to the credit of the commissioner's office and must be used to support the database.

NEW SECTION. **Section 6. Duty to report claims data to all-payer claims database.** A health plan or third-party administrator that meets the requirements of [section 5] shall provide claims data to the database as required under [sections 1 through 6]. A health plan or third-party administrator that fails to comply with the reporting requirements is subject to the penalty provided for in [section 5].

Section 7. Section 2-18-702, MCA, is amended to read:

"2-18-702. Group insurance for public employees and officers. (1) (a) Except as provided in subsection (1)(c), all counties, cities, towns, school districts, and the board of regents shall upon approval by two-thirds vote of their respective officers and employees enter into group hospitalization, medical, health, including long-term disability, accident, or group life insurance contracts or plans for the benefit of their officers and employees and their dependents. The laws prohibiting discrimination on the basis of marital status in Title 49 do not prohibit bona fide group insurance plans from providing greater or additional contributions for insurance benefits to employees with dependents than to employees without dependents or with fewer dependents.

(b) The governing body of a county, city, or town may, at its discretion, consider the employees of private, nonprofit economic development organizations, hospitals, health centers, or nursing homes to be employees of the county, city, or town solely for the purpose of participation in group hospitalization, medical, health, including long-term disability, accident, or group life insurance contracts or plans as provided in subsection (1)(a). The governing body of the county, city, or town may require an employee, organization, hospital, health center, or nursing home to pay the actual cost of coverage required for participation or may, at its discretion and subject to any restriction on who may be a member of a group, pay all or part of the cost of coverage of the employee of the organization.

(c) The governing body of a county having a taxable valuation of less than $30 million or the board of trustees of a hospital district may, at its discretion, exempt employees of a county hospital, county rest home or nursing home, or hospital district from participation in group hospitalization, medical, health, including long-term disability, accident, or group life insurance contracts or plans provided pursuant to subsection (1)(a) or (1)(b).

(2) A group contract or plan for major medical coverage offered under this section must provide claims information to the Montana all-payer claims database as required under [sections 1 through 6].

~~(2)~~(3) State employees and elected officials, as defined in 2-18-701, may participate in state employee group benefit plans as are provided for under part 8 of this chapter.

~~(3)~~(4) For state officers and employees, the premiums required from time to time to maintain the

insurance in force must be paid by the insured officers and employees, and the state treasurer shall deduct the premiums from the salary or wages of each officer or employee who elects to become insured, on the officer's or employee's written order, and issue a warrant for the premiums to the insurer.

~~(4)~~(5) For the purpose of this section, the plans of health service corporations for defraying or assuming the cost of professional services of licensees in the field of health or the services of hospitals, clinics, or sanitariums or both professional and hospital services must be construed as group insurance and the dues payable under the plans must be construed as premiums for group insurance.

~~(5)~~(6) If the board of trustees of a school district implements a self-insured group health plan or if the board of regents implements an alternative to conventional insurance to provide group benefits to its employees, the board shall maintain the alternative plan on an actuarially sound basis."

Section 8. 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:

(a) the provisions of [sections 1 through 6]; or

(b) 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, part 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) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-138, 33-22-141, 33-22-142, 33-22-152, 33-22-153, 33-22-156 through 33-22-159, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, 33-22-706[, and Title 33, chapter 40, part 1,] apply to health maintenance organizations. (Bracketed language in (7) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

Section 9. 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) [sections 1 through 6];

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

~~(d)~~(e) 33-3-308;

~~(e)~~(f) Title 33, chapter 18, except 33-18-242;

~~(f)~~(g) Title 33, chapter 19;

~~(g)~~(h) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-141, 33-22-142, 33-22-152, and 33-22-153;

~~(h)~~(i) 33-22-512, 33-22-515, 33-22-525, and 33-22-526; and

~~(i)~~(j) Title 33, chapter 40, part 1.

(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.

(Subsection ~~(1)(i)~~ (1)(j) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

NEW SECTION. **Section 10. Appropriation.** There is appropriated $74,500 from the state general fund to the state auditor's office for each year of the biennium beginning July 1, 2015, to establish and operate the Montana all-payer claims database as provided in [sections 1 through 6].

NEW SECTION. **Section 11. Codification instruction.** [Sections 1 through 6] are intended to be codified as an integral part of Title 33, chapter 1, and the provisions of Title 33, chapter 1, apply to [sections 1 through 6].

NEW SECTION. **Section 12. Effective date.** [This act] is effective July 1, 2015.

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