SENATE BILL NO. 448

INTRODUCED BY V. RICCI, C. SCHOMER, E. BUTTREY, C. HINKLE, J. ETCHART, J. KARLEN

A BILL FOR AN ACT ENTITLED: “AN ACT GENERALLY REVISING LAWS RELATED TO PAYMENTS MADE BY HEALTH CARRIERS; PROVIDING PROMPT PAYMENT REQUIREMENTS; PROVIDING FOR CLEAN CLAIM PROCEDURES; PROVIDING FOR CLAIM DEFICIENCY NOTIFICATIONS; PROVIDING PENALTIES; PROVIDING ENFORCEMENT AUTHORITY BY THE COMMISSIONER OF INSURANCE; PROVIDING ENFORCEMENT AUTHORITY BY THE DEPARTMENT OF JUSTICE; PROVIDING FOR A PRIVATE RIGHT OF ACTION; PROVIDING DEFINITIONS; AMENDING SECTION 33-31-111, 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) "Applicable number of calendar days" means:

(a) for claims submitted electronically, 14 calendar days; and

(b) for claims submitted otherwise, 30 calendar days.

(2) "Clean claim" means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim.

(3) "Enrollee" means an individual who is enrolled in a health benefits plan offered by a health carrier.

(4) "Facility" means an institution providing health care services or a health care setting and includes:

(a) hospitals;

(b) federally qualified health centers as defined by the Public Health Service Act, 42 U.S.C. 254b;

(c) skilled nursing centers;

(d) residential treatment centers;

(e) diagnostic, laboratory, and imaging centers;

(f) rehabilitation and other therapeutic health settings; and

(g) other licensed inpatient centers.

(5) "Health benefits plan" means a group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for health care services.

(6) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with Montana law.

(7) "Health care provider" or "provider" means a health care professional or facility.

(8) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(9) "Health care supplier" or "supplier" means a pharmacy or medical equipment supplier licensed, accredited, or certified to furnish supplies in the state consistent with Montana law.

(10) "Health carrier" means an entity subject to the insurance laws and rules of this state and that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, or any other entity providing a plan of health insurance, health benefits, or health care services. The term includes a disability insurer, health maintenance organization, or a health service corporation or other entity providing a health benefit plan.

NEW SECTION. **Section 2. Prompt payment requirement.** Each health carrier offering a health benefits plan in this state:

(1) shall provide prompt payment of claims submitted by health care providers for services and supplies furnished to enrollees of its health benefits plans in accordance with the requirements of [sections 1 through 8];

(2) may not pend or delay adjudication of claims for any reason not specified in [sections 1 through 8]; and

(3) is subject to the penalties under [sections 6 through 8] for any circumstance in which a delay in

processing or payment is made due to the health benefits plan's mistake or error.

NEW SECTION. **Section 3. Prompt payment of clean claims.** (1) Each health carrier offering a health benefits plan in this state shall provide that, in accordance with [sections 1 through 8], payment shall be issued, mailed, or otherwise transmitted, with respect to each clean claim submitted for health care services or supplies furnished by a health care provider or supplier to an enrollee of a health benefits plan by no later than the applicable number of calendar days after the date on which the claim is received.

(2) A claim, or other information, is considered to be received:

(a) for claims or information submitted electronically, on the date on which the claim or information is transferred to the health benefits plan; and

(b) for claims or information otherwise submitted, on the fifth day after the postmark date of the claim or information, or the date specified in the time stamp of the transmission.

NEW SECTION. **Section 4. Procedures involving clean claims.** (1) A claim for items or health care services furnished by a health care provider or supplier to an individual enrolled in a health benefits plan offered by a health carrier is considered a clean claim and must be paid by a health carrier in accordance with [sections 1 through 8] in each of the following cases:

(a) when a claim satisfies the criteria specified in subsection (2);

(b) when the health carrier does not provide notice to the health care provider or supplier of any deficiency in the claim by not later than the deficiency notification date specified in [section 5];

(c) when additional documentation is requested under [section 5] for a claim, if the health carrier does not provide notice to the provider of services or supplier of any defect or impropriety in the claim not later than 10 days after the date on which additional information is received, as determined under [section 3], by the health carrier in response to a request under [section 5]; or

(d) when the claim is not paid or contested by the health carrier within the applicable number of calendar days, determined under [section 1], after the date on which the claim is received.

(2) For the purposes of subsection (1)(a), the criteria, with respect to a claim for items or health care services furnished by a health care provider or supplier to an individual enrolled in the health benefits plan,

are that:

(a) the claim satisfies the standards and includes the data elements adopted under section 1173(a)(1) of the Social Security Act, 42 U.S.C. 1320d--2, for transactions with respect to health claims or equivalent encounter information, including with respect to identifying the item or service furnished, the provider of services or supplier, the individual who furnishes the item or service, the date and location the item or service is furnished, and any information with respect to an applicable prior authorization requirement; and

(b) the claim submission includes all documentation required under the contract between the plan and the provider or supplier with respect to payment for the items or services.

NEW SECTION. **Section 5. Claim determined not to be clean claim -- deficiency notification.** (1) (a) If a health carrier determines that a claim submitted with respect to a provider of services or supplier is not a clean claim, the health carrier shall, not later than the deficiency notification date described in subsection (2), notify the provider of services or supplier of the determination. The notification shall specify all defects or improprieties in the claim and shall list all additional information or documents necessary for the proper processing and payment of the claim.

(b) A subsequent request by the health carrier for additional information or documents for the proper processing and payment of the claim must be limited to addressing the defects and improprieties identified in the notification provided pursuant to this section and to the additional information and documents listed in the notification.

(2) The deficiency notification date is:

(a) for a claim submitted electronically, the date that is 10 calendar days after the date on which the claim is received; and

(b) for a claim submitted otherwise, the date that is 15 calendar days after the date on which the claim is received.

NEW SECTION. **Section 6. Failure to render timely payment of clean claim -- interest payment.** (1) (a) Except as provided in subsection (2), if payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days after a clean claim is received, the health carrier shall pay interest to the

provider or supplier that submitted the claim.

(b) The interest payment must be at a rate equal to the weighted average of interest on 3-month marketable treasury securities determined for the period, increased by 0.1 percentage point for the period beginning on the day after the required payment date and ending on the date on which payment is made.

(c) Interest amounts paid under this subsection (1) may not be counted against the administrative costs of a health benefits plan for the purposes of determining the medical loss ratio of the plan.

(2) The commissioner may provide that a health carrier is not charged interest under subsection (1) in a case in which there are exigent circumstances, including natural disasters and other unique and unexpected events that prevent the timely processing of claims.

(3) Payment of a clean claim is considered to have been made on the date on which:

(a) for claims paid electronically, the payment is transferred; and

(b) for claims paid otherwise, the payment is submitted to the United States postal service or a common carrier for delivery.

(4) A health carrier shall pay all clean claims submitted electronically, and any interest charged under subsection (1), in the manner selected by the provider, including by the standards for electronic fund transfers established in section 1173 of the Social Security Act, 42 U.S.C. 1320d--2, which may not be subject to a transactional fee assessed by the health plan or any vendor acting on the plan's behalf.

NEW SECTION. **Section 7. Rights of claimants -- anti-retaliation -- rules of construction.** (1) Nothing in [sections 1 through 8] may be construed to prohibit or limit a claim or action not covered by the subject matter of [sections 1 through 8] that any individual or organization has against a provider or health carrier.

(2) Consistent with applicable law, a health carrier may not retaliate against an individual or provider for exercising a right of action under subsection (1).

(3) A determination under the provisions of [sections 1 through 8] that a claim submitted is a clean claim may not be construed as a positive determination regarding eligibility for payment under [sections 1 through 8], nor is it an indication of government approval of, or acquiescence regarding, the claim submitted. The determination may not relieve any party of civil or criminal liability with respect to the claim, nor does it offer

a defense to any administrative, civil, or criminal action with respect to the claim.

(4) (a) Except as provided in subsection (4)(b), no writing or other agreement may contain any provision that constitutes a waiver, modification, or nullification of any requirement or remedy provided for in [sections 1 through 8].

(b) Nothing in [sections 1 through 8] prohibits a writing or other agreement that grants to a health care provider more protection or relief than contained in [sections 1 through 8] or a waiver given in settlement of a dispute or action.

(5) The rights and remedies established in [sections 1 through 8] are in addition to all other rights and remedies provided by law. Neither the rights and remedies established by this section, or any other provision of [sections 1 through 8], supersedes, restricts, or limits the application of any provision of state or federal law.

(6) Nothing in [sections 1 through 8] authorizes or requires conduct that is prohibited by state or federal law.

(7) No provisions in [sections 1 through 8] are intended to conflict with federal law, which supersedes [sections 1 through 8].

NEW SECTION. **Section 8. Noncompliance -- penalties -- enforcement by department of justice -- private right of action.** (1) If the commissioner determines that a health carrier is not in compliance with [sections 1 through 8], the commissioner may impose the penalties described in this section, including administrative fees, restitution, or any other remedy available under state law, including the remedies and enforcement authority available under Title 33, chapter 1, part 3.

(2) The remedies available under this section are:

(a) civil penalties of not more than $25,000 for each determination of noncompliance under subsection (1); and

(b) civil penalties of not more than $10,000 for each week beginning on and after the date on which a civil penalty under subsection (2)(a) is imposed by the commissioner during which the deficiency that is the basis of a determination under subsection (1) exists.

(3) Any fee charged or allocated for collection activities conducted by the commissioner must be

assessed to a health benefits plan on a pro-rata basis and added to any penalty fee collected from the plan.

(4) If the commissioner determines that any health care provider or enrollee was adversely affected by the noncompliance of the health carrier described in subsection (1), the commissioner may determine an amount necessary to compensate the provider or enrollee for the harm attributable to the noncompliance that is not otherwise compensated. The commissioner may require the health carrier to pay the amount, including appropriate interest, to a provider or enrollee in addition to the other penalties under this section.

(5) The department of justice may bring a civil action in an appropriate court for declaratory or injunctive relief as is necessary to carry out [sections 1 through 8].

(6) (a) A person who is aggrieved by a violation of [sections 1 through 8] may provide written notice of the violation to the commissioner.

(b) If the violation is not corrected within 90 days after receipt of a notice under subsection (6)(a), the aggrieved person may bring a civil action in a court of competent jurisdiction for declaratory or injunctive relief with respect to the violation.

(7) In a civil violation under this section, the court may allow a prevailing party, other than the state, reasonable attorney fees, including litigation expenses and costs.

Section 9. 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; 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; [sections 1 through 8]; and Title 33, chapter 32."

NEW SECTION. **Section 10. Codification instruction.** [Sections 1 through 8] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 8].

NEW SECTION. **Section 11. Applicability.** [This act] applies to claims filed on or after January 1, 2026.

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