SB 321

Establish an insulin price cap. Each individual policy of disability insurance or certificate issued that contains coverage for prescription drugs must, for at least one insulin in each category of insulin, limit the insured’s required copayment or other cost-sharing requirement to $40 for each 30-day supply of covered insulin, regardless of the amount of insulin prescribed. And coverage of insulin prescribed for an insured is not subject to a deductible.

HB 295

Allow licensed clinical social workers and therapists to treat chronic pain.

HB 378

Create a mini-COBRA law for small employer health insurance plans. Allows employees of small employers to elect continuation of insurance coverage on termination of employment.

HB 508

Establish cap on insulin cost-sharing requirements. Each individual policy of disability insurance or certificate issued that contains coverage for prescription drugs must, for at least one insulin in each category of insulin, limit the insured’s required copayment or other cost-sharing requirement to $100 for each 30-day supply of covered insulin, regardless of the amount of insulin prescribed. And coverage of insulin prescribed for an insured is not subject to a deductible.

HB 679

Establish wholesale drug importation program for life-sustaining drugs or drugs that maintain a healthy standard of living. The department and board, in consultation with appropriate federal and state agencies and other interested parties, shall design a wholesale prescription drug importation program that complies with the applicable requirements of 21 U.S.C. 384, including the requirements regarding safety and cost savings. The department and board shall consult with the office of the attorney general to identify the potential for and to monitor for anticompetitive behavior in industries that would be affected by the program.

SB 253

Revise state income tax medical care savings account investment options. An act generally revising medical care savings account laws; allowing investment of medical care savings account funds in stocks, bonds, and mutual funds; providing that investment options that qualify under a federal health savings account are permissible; providing a transition clause to allow a tax-free rollover from an existing medical care savings account; amending section 15-61-204, MCA; and providing an immediate effective date and a retroactive applicability date.

Spotlight on State: Montana

This is part of a series of summaries that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.

See Montana page.

Montana promotes the use of telemedicine by providing coverage and cost-sharing parity between telemedicine and in-person services. Coverage for telemedicine services must be equivalent to the coverage for in-person services. To make telemedicine services more affordable to patients, cost-sharing requirements that are not generally applicable to in-person services may not be imposed on telemedicine services.

Montana continues to actively pursue legislation to promote price transparency, with multiple efforts focused on

implementing surprise billing protections. In recent sessions, legislators introduced legislation that would have required certain health care facilities to provide cost information on services expected to exceed $500, as well as establish procedures for informing consumers about out-of-network health care costs. A similar bill would have established limits on a consumer's out-of-network costs under certain circumstances and implemented procedures about informing consumers about the ability to opt out of services. In 2016, the state unsuccessfully attempted to create an All-Payer Claims Database (APCD), which would require health plans to submit claims information or be subject to a penalty. In another effort to improve transparency and drive down prices, the legislature proposed to study the effects of reference-based pricing on health care prices and transparency in health care pricing.

In the healthcare market, Montana exercises regulatory oversight over provider mergers by requiring pre-transaction notice to and approval from the attorney general or court for transactions involving certain public benefit or religious corporations. The legislature repealed the state's certificate of public advantage law in 2019. Additionally, in 2013, the legislature approved a bill to grant the commissioner of insurance rate-setting authority.

To stabilize the individual insurance market, Montana enacted the Montana Reinsurance Association Act establishing the Montana Reinsurance Association and Program. The bill also authorized the state to apply for a State Innovation Waiver and federal pass-through funding to partially finance the reinsurance program under section 1332 of the Patient Protection and Affordable Care Act (PAACA). The state received an approved State Innovation Waiver from the federal government for the period January 1, 2020 through December 31, 2024. The reinsurance program will pay insurers up to 60% of claims paid

between $40,000 and an estimated $101,750 cap.

Healthcare Affordability State Policy Scorecard

HB 231

Revise laws relating to certificate of need. AN ACT REVISING CERTIFICATES OF NEED TO INCLUDE ONLY LONG-TERM CARE FACILITIES AND SERVICES; AND AMENDING SECTIONS 50-5-101, 50-5-301, 50-5-302, 50-5-304, 50-5-307, 50-5-308, 50-5-309, AND 53-6-110, MCA.

New on The Source: Downloadable Chart of Merger Review Legal Authority for All

50 States

Newly available on the Source: our health policy research team compiled a user-friendly, downloadable Excel spreadsheet of all provider merger review authority for all 50 states, now on the Market Consolidation interactive key issue page. The detailed chart provides clickable citations of all statutes, regulations, and state authority for mergers, acquisitions, conversions, or changes in ownership of healthcare providers.

The comprehensive spreadsheet allows side-by-side comparisons of the level of legal authority for each state to receive notice of impending transactions, review those transactions, and approve, conditionally approve, or disapprove them. It is conveniently organized by each type of state entity:

- Attorney general notice, approval, and review criteria
- Court approval requirement and criteria
- State health agency notice, approval and review criteria
- Certificate of Need (CON) notice, approval, and review criteria

Click on each citation for a direct link to the statutory text and other detailed information as provided by the Database of State Laws Impacting Healthcare Cost and Quality (SLIHCQ). All laws and regulations are current as of July 2021.

Click here to download.