SENATE BILL NO. 128

INTRODUCED BY HARGROVE, FRANKLIN

BY REQUEST OF THE GOVERNOR AND THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE; CREATING A NETWORK AND QUALITY REVIEW COUNCIL; PROVIDING FOR THE POWERS AND DUTIES OF THE BOARD AND COUNCIL; PROVIDING FOR STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS 33-22-1703, 33-22-1706, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND PROVIDING EFFECTIVE DATES AND AN APPLICABILITY DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section 15] requires rules to be adopted by the board of network adequacy and quality assurance and because [sections 20, 27, and 29] require the department of public health and human services to adopt rules.

The rules adopted by the board of network adequacy and quality assurance must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 11 through 35] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 11 through 35].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 11 through 35], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of national accrediting organizations. Because foreclosure of small managed care plans is not in the best interests of Montana health care consumers, state quality assurance standards for small managed care plans must be adopted in order to enable small managed care plans to proliferate, while at the same time protecting the interests of managed care consumers in Montana. Therefore, appropriate standards must be adopted for small

managed care plans that cannot comply with all of the standards used by national accrediting organizations.

In order to promote uniformity of standards applicable to all managed care plans, state quality assurance standards for small managed care plans must consist of a selection of health plan employer data and information set standards. By requiring use of some of these standards and prohibiting use of any standards in addition to the health plan employer data and information set standards adopted as state standards for small managed care plans, the legislature intends to require managed care plans that are not accredited by national accrediting organizations to conform to the same basic set of standards as larger accredited managed care plans.

The board of network adequacy and quality assurance may refer reports of noncompliance by a health carrier to the commissioner for corrective action. Under the board's rulemaking authority, the board shall adopt processes under which the board and the network and quality review council undertake regulation of managed care plans, specify the considerations affecting board and council decisions relating to managed care plans, and specify network adequacy and quality assurance review processes.

The department of public health and human services is required to adopt rules pursuant to [section 20] providing for verification of the professional credentials of managed care network providers. The department shall adopt minimum requirements related to licensing, the history of licensure, professional liability coverage, hospital privileges, the status of specialty board certification, a drug enforcement agency registration certificate, the completion of graduate and postgraduate training, and other considerations as determined by the department to ensure that participating providers meet minimum levels of professional qualification. A health carrier may require additional credentials. However, providers shall meet any minimum standards adopted by the department. The department shall adopt standards that do not prohibit the development of managed care networks in both rural and urban areas of Montana and that ensure the availability of quality care from qualified providers to participants in a managed care program.

[Section 24] designates the department of public health and human services as the place for insurance carriers to file documents related to managed care provider network adequacy and quality assurance. The department shall adopt rules establishing procedures for filing these documents and shall adopt rules specifying processes for amending or withdrawing documents already filed that relate to network adequacy.

Rules providing state network adequacy and quality assurance standards, other than provider credential verification requirements, may be adopted only by the board of network adequacy and quality

assurance.

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

NEW SECTION. **Section 1. Board of network adequacy and quality assurance.** (1) There is a board of network adequacy and quality assurance. The board is composed of a medical director, the director of the department of public health and human services provided for in 2-15-2201, and the commissioner of insurance provided for in 2-15-1903.

(2) The medical director is appointed by the governor and must be licensed as a physician by the state of Montana. The medical director must be appointed from the list of physician specialties provided in [section 2(2)]. The governor may remove a medical director at any time and appoint a new medical director to the position.

(3) The medical director is entitled to compensation in an amount determined by the governor, under guidelines adopted by the governor.

(4) The general powers and duties of the board are provided in [section 15], and the board receives staff assistance as provided in [section 17].

(5) The provisions of 2-15-122(5) through (8) apply to the board and its members. However, the governor shall determine the compensation of the medical director as provided in subsection (3).

(6) The board is attached for administrative purposes to the department of public health and human services pursuant to 2-15-121.

NEW SECTION. **Section 2. Network and quality review council.** (1) There is a network and quality review council. The council consists of six health care providers, one health insurance carrier quality assurance specialist, and one health care consumer representative who is not affiliated with the health care or insurance industry. The medical director provided for in [section 1] presides over meetings of the council.

(2) The medical director occupies one of the six health care provider positions on the council. The board of network adequacy and quality assurance provided for in [section 1] shall appoint the remaining five health care providers to the council and shall ensure that one family practice physician, one pediatric physician, one internal medicine physician, one obstetrician/gynecologist, and one specialist serve as

members of the council. The board shall also appoint:

(a) a physician assistant-certified licensed pursuant to Title 37, chapter 20;

(b) an advanced-practice registered nurse licensed pursuant to Title 37, chapter 8, part 4; or

(c) a registered nurse licensed pursuant to Title 37, chapter 8, who is nationally certified in quality assurance or who has current experience in the field of quality assurance and network adequacy.

(3) The commissioner of insurance provided for in 2-15-1903 shall appoint a health insurance carrier quality assurance specialist to the council.

(4) The director of the department of public health and human services, provided for in 2-15-2201, shall appoint the health care consumer representative to the council.

(5) (a) The initial council members' terms, not including the medical director, are as follows and must be assigned by lot:

(i) two of the members serve a term of 1 year;

(ii) two of the members serve a term of 2 years; and

(iii) three of the members serve a term of 3 years.

(b) Subsequent council members serve for a term of 3 years.

(c) A member of the council may be replaced for cause by the appointing authority. A vacancy on the council is filled by the appointing authority. A council member's term continues until that member's successor is appointed. A member of the council may be reappointed.

(6) The general powers and duties of the council are provided for in [section 16], and the council receives staff assistance as provided in [section 17].

(7) The provisions of 2-15-122(5) through (8) apply to the council and its members. However, the medical director serves as presiding officer of the council.

(8) The council is attached for administrative purposes to the department of public health and human services pursuant to 2-15-121.

Section 3. Section 33-22-1703, MCA, is amended to read:

"**33-22-1703. Definitions.** As used in this part, the following definitions apply:

(1) "Emergency services" means services provided after ~~suffering an accidental bodily injury or the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that without immediate medical attention the subscriber or insured could reasonably expect~~

~~that:~~

~~(a) the subscriber's or insured's health would be in serious jeopardy;~~

~~(b) the subscriber's or insured's bodily functions would be seriously impaired; or~~

~~(c) a bodily organ or part would be seriously damaged~~ a sudden and unexpected onset of a serious illness or bodily injury, which, if not treated immediately, may result in serious medical complications, loss of life, permanent impairment of bodily functions, serious dysfunction of a bodily organ or part, or placement of the covered person's health in serious jeopardy.

(2) "Health benefit plan" means the health insurance policy or subscriber arrangement between the insured or subscriber and the health care insurer that defines the covered services and benefit levels available.

(3) "Health care insurer" means:

(a) an insurer that provides disability insurance as defined in 33-1-207;

(b) a health service corporation as defined in 33-30-101;

~~(c) a health maintenance organization as defined in 33-31-102;~~

~~(d)~~(c) a fraternal benefit society as described in 33-7-105; or

~~(e)~~(d) any other entity regulated by the commissioner that provides health coverage, except a health maintenance organization.

(4) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization or services provided under Title 33, chapter 22, part 7.

(5) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

(6) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

(7) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider.

(8) "Provider" means an individual or entity licensed or legally authorized to provide health care services or services covered within Title 33, chapter 22, part 7.

(9) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

Section 4. Section 33-22-1706, MCA, is amended to read:

"**33-22-1706. Permissible and mandatory provisions in provider agreements, insurance policies, and subscriber contracts.** (1) A provider agreement, insurance policy, or subscriber contract issued or delivered in this state ~~may~~ must contain certain other components designed to control the cost and improve the quality of health care for insureds and subscribers~~, including~~. These components may include:

(a) a provision setting a payment difference for reimbursement of a nonpreferred provider as compared to a preferred provider. If the health benefit plan contains a payment difference provision, the payment difference may not exceed 25% of the reimbursement level at which a preferred provider would be reimbursed. The commissioner shall review differences between copayments, deductibles, and other cost-sharing arrangements.

(b) conditions, not inconsistent with other provisions of this part, designed to give policyholders or subscribers an incentive to choose a particular provider~~.~~;

(c) the review or control of use of health care services; and

(d) a procedure for determining whether health care services are medically necessary.

(2) All terms or conditions of an insurance policy or subscriber contract, except those already approved by the commissioner, are subject to the prior approval of the commissioner.

(3) A plan offering prepaid dental services under this part must offer its insureds the right to obtain dental care from any licensed dental care provider of their choice, subject to the same terms and conditions imposed under subsection (1)."

Section 5. Section 33-22-1707, MCA, is amended to read:

"**33-22-1707. Rules.** The commissioner ~~shall~~ may promulgate rules necessary to implement the provisions of this part."

Section 6. Section 33-31-102, MCA, is amended to read:

"**33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

(e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to 33-31-301(3)(e);

(f) care and treatment of mental illness, alcoholism, and drug addiction;

(g) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(h) preventive health services, including:

(i) immunizations;

(ii) well-child care from birth;

(iii) periodic health evaluations for adults;

(iv) voluntary family planning services;

(v) infertility services; and

(vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction;

(i) minimum mammography examination, as defined in 33-22-132; and

(j) treatment for phenylketonuria. "Treatment" means licensed professional medical services under the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels of phenylalanine and adequate nutritional status.

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

(3) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

(4) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(5) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

(6) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(7) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid ~~or other financial~~ basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers. This subsection does not limit methods of provider payments made by health maintenance organizations.

(8) "Insurance producer" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(9) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(10) "Plan" means a health maintenance organization operated by an insurer or health service corporation as an integral part of the corporation and not as a subsidiary.

(11) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of ~~his~~ the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

(12) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent."

Section 7. 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 any 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 ~~may not be construed as~~ is not a violation of any law relating to solicitation or advertising by health professionals.

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

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

(5) ~~The provisions of this~~ This section ~~do~~ does not exempt a health maintenance organization from material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization ~~must be~~ is considered an insurer for the purposes of 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from network adequacy and quality assurance requirements provided under [sections 11 through 35]."

Section 8. Section 33-31-211, MCA, is amended to read:

"**33-31-211. Annual ~~statement~~ statements -- revocation for failure to file -- penalty for false swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file on or before June 1 an audited financial statement.

(2) At the time of filing ~~its~~ the annual statement required by March 1, the health maintenance organization shall pay the commissioner the fee for filing ~~its~~ the statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, or may ~~in his discretion~~ suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed $5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he considers~~ considered reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ duties ~~under~~ required of the commissioner by this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

Section 9. Section 33-31-216, MCA, is amended to read:

"**33-31-216. Protection against insolvency.** (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of ~~its~~ operation ~~must be the greater of:~~ is $200,000.

~~(a) 5% of its estimated expenditures for health care services for its first year of operation;~~

~~(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~

~~(c) $100,000.~~

(3) At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on October 1, 1987, shall make a deposit equal to the greater of:

(a) 1% of the preceding 12 months' uncovered expenditures; or

(b) ~~$100,000 on the first day of the fiscal year beginning 6 months or more after October 1, 1987. In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit must be equal to~~ 4% of its estimated annual uncovered expenditures for each year. ~~Each year's estimate after the first year of operation must reasonably reflect the preceding year's operating experience and delivery arrangements.~~

(5) The commissioner may ~~in his discretion~~ waive any of the deposit requirements set forth in subsections (1) through (4) whenever ~~he~~ the commissioner is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to ~~assure~~ ensure its financial viability for the next year;

(b) the health maintenance organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to ~~assure~~ ensure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth, not including land, buildings, and equipment, of at least $1 million or achieves a net worth, including organization-related land, buildings, and equipment, of at least $5 million, the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth, not including land, buildings, and equipment, of at least $1 million or that has been in operation for at least 10 years and has a net worth, including organization-related land, buildings, and equipment, of at least $5 million, the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of ~~such~~ those health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the

guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth~~, except that its~~. However, the health maintenance organization's total deposit ~~may~~ is not ~~be~~ required to exceed the maximum required under this section.

(9) Unless it is operated by an insurer or a health service corporation as a plan, each health maintenance organization ~~shall~~ must have a minimum capital of at least $200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

(a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

(b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical underwriting or preexisting limitation requirements."

NEW SECTION. **Section 10. Premium increase restriction -- exception.** (1) A health maintenance organization may not increase a premium for an individual's or an individual's group health care services agreement more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the health maintenance organization in violation of the laws of this state; or

(b) cause the financial impairment of the health maintenance organization to the extent that further

transaction of insurance by the health maintenance organization would injure or be hazardous to its enrollees or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, by a court decision, by a state rule, or by a federal regulation.

NEW SECTION. **Section 11. Short title.** [Sections 11 through 35] may be cited as the "Managed Care Plan Network Adequacy and Quality Assurance Act".

NEW SECTION. **Section 12. Purpose.** The purpose and intent of [sections 11 through 35] are to:

(1) establish standards for the creation and maintenance of networks by health carriers offering managed care plans and to ensure the adequacy, accessibility, and quality of health care services offered under a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons;

(2) provide for the powers and duties of the board council in order to adopt and implement state network adequacy and quality assurance standards in administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for detecting and reporting violations of those standards to the commissioner;

(3) establish minimum criteria for the quality assessment activities of a health carrier issuing a closed plan or a combination plan and to require that minimum state quality assessment criteria be adopted by rule;

(4) enable health carriers to evaluate, maintain, and improve the quality of health care services provided to covered persons; and

(5) provide a streamlined and simplified process by which managed care network adequacy and quality assurance programs may be monitored for compliance through the coordinated efforts of the commissioner, the department, the board, and the council. It is not the purpose or intent of [sections 11 through 35] to apply quality assurance standards applicable to medicaid or medicare to managed care plans regulated pursuant to [sections 11 through 35] or to create or require the creation of quality assurance programs as comprehensive as quality assurance programs applicable to medicaid or medicare.

NEW SECTION. **Section 13. Definitions.** As used in [sections 11 through 35], the following definitions apply:

(1) "Board" means the board of network adequacy and quality assurance provided for in [section 1].

(2) "Closed plan" means a managed care plan that requires covered persons to use only participating providers under the terms of the managed care plan.

(3) "Combination plan" means an open plan with a closed component.

(4) "Council" means the network and quality review council provided for in [section 2].

(5) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(6) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating in a health benefit plan.

(7) "Department" means the department of public health and human services established in 2-15-2201.

(8) "Emergency medical condition" means the sudden and unexpected onset of a serious illness or bodily injury, which, if not treated immediately, may result in serious medical complications, loss of life, permanent impairment of bodily functions, serious dysfunction of a bodily organ or part, or placement the covered person's health in serious jeopardy.

(9) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(10) "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

(11) "Health benefit plan" means a policy, contract, certificate, or agreement 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.

(12) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

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

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

(15) "Health carrier" means an entity subject to the insurance laws and rules of this state 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, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.

(16) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

(17) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier.

(18) "Network" means the group of participating providers that provides health care services to a managed care plan.

(19) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

(20) "Participating provider" means a provider who, under a contract with a health carrier or with the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(21) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health care services rendered to the covered person.

(22) "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations.

(23) "Quality assurance" means quality assessment and quality improvement.

(24) "Quality improvement" means an effort to improve the processes and outcomes related to the provision of health care within a health plan.

NEW SECTION. **Section 14. Applicability and scope.** [Sections 11 through 35] apply to all health carriers that offer managed care plans. [Sections 11 through 35] do not exempt a health carrier from the applicable requirements of federal law when providing a managed care plan to medicare recipients or from the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to medicaid recipients.

NEW SECTION. **Section 15. Board -- general powers and duties -- rulemaking.** (1) The board shall:

(a) adopt rules pursuant to the Montana Administrative Procedure Act establishing minimum state standards for network adequacy and quality assurance and procedures for ensuring compliance with those standards; and

(b) recommend action to the commissioner against a health carrier whose managed care plan does not comply with standards for network adequacy and quality assurance adopted by the board.

(2) Quality assurance standards adopted by the board must consist of some but not all of the health plan employer data and information set standards. The board shall select and adopt from the health plan employer data and information set standards only standards appropriate for quality assurance in Montana. The board may not adopt as a state standard a standard that imposes a requirement in addition to the health plan employer data and information set standards or a standard that is not included in the health plan employer data and information set standards.

NEW SECTION. **Section 16. Council -- general powers and duties.** (1) The council shall:

(a) make recommendations to the board for state network adequacy and quality assurance standards;

(b) annually review the state network adequacy and quality assurance standards provided in [sections 18 through 26] and the rules implementing [sections 18 through 26] and recommend amendments to those standards to the board;

(c) annually review a health carrier's quality assessment program in accordance with standards established in [sections 28 through 34] and the rules implementing [sections 28 through 34];

(d) annually review a health carrier's quality improvement plan or program in accordance with standards established in [sections 28 through 34] and the rules implementing [sections 28 through 34]; and

(e) annually review managed care plan networks for compliance with standards for network adequacy provided in [sections 18 through 26] and the rules implementing [sections 18 through 26].

(2) The council may:

(a) recommend changes to a health carrier in the health carrier's quality assessment program, quality improvement plan or program, quality assurance program, or network adequacy;

(b) recommend to the board corrective action necessary for the health carrier to achieve compliance with state network adequacy and quality assurance standards;

(c) make recommendations to individual health care providers or to appropriate professional and occupational licensing boards provided in Title 37 concerning compliance with state network adequacy and quality assurance standards; and

(d) request and obtain the assistance of other health care providers in developing quality assurance standards and determining corrective action.

NEW SECTION. **Section 17. Staff assistance.** The department and the commissioner shall:

(1) provide staff assistance to the board and the council;

(2) provide information to the board and the council as requested; and

(3) employ network adequacy and quality assurance analysts for the purposes of ensuring that health carriers and their representatives comply with state network adequacy and quality assurance standards provided in [sections 11 through 35].

NEW SECTION. **Section 18. Network adequacy -- standards -- access plan required.** (1) A health carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and types of providers to ensure that all services to covered persons are accessible without unreasonable delay. Sufficiency in number and type of provider is determined in accordance with the requirements of this section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria may include but are not limited to:

(a) a ratio of specialty care providers to covered persons;

(b) a ratio of primary care providers to covered persons;

(c) geographic accessibility;

(d) waiting times for appointments with participating providers;

(e) hours of operation; or

(f) the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(2) Whenever a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the covered benefit were obtained from participating providers or shall make other arrangements acceptable to the department.

(3) The health carrier shall establish and maintain adequate provider networks to ensure reasonable proximity of participating providers to the businesses or personal residences of covered persons. In determining whether a health carrier has complied with this requirement, consideration must be given to the relative availability of health care providers in the service area under consideration.

(4) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability, and legal authority of its providers to furnish all covered benefits to covered persons.

(5) A health carrier offering a managed care plan in this state on October 1, 1998, shall file with the department on October 1, 1998, an access plan complying with subsection (7) and the rules of the department. A health carrier offering a managed care plan in this state for the first time after October 1, 1998, shall file with the department an access plan meeting the requirements of subsection (7) and the rules of the department before offering the managed care plan. A plan must be filed with the department in a manner and form complying with the rules of the department.

(6) A health carrier may request the department to designate parts of its access plan as proprietary or competitive information, and when designated, that part may not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. A health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide a copy of the plan upon request.

(7) An access plan for each managed care plan offered in this state must describe or contain at least the following:

(a) a listing of the names and specialties of the health carrier's participating providers;

(b) the health carrier's procedures for making referrals within and outside its network;

(c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in the managed care plan;

(d) the health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(e) the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(f) the health carrier's method of informing covered persons of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(g) the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians and for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(h) the health carrier's process for enabling covered persons to change primary care professionals;

(i) the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and a participating provider or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and be transferred to other providers in a timely manner.

(j) any other information required by the board or council to determine compliance with [sections 18 through 26] and the rules implementing [sections 18 through 26].

(8) A health carrier shall on October 1, 1999, and annually each October 1 after that date update a managed care plan access plan previously filed with the department. If a change has not been made by the health carrier to a managed care plan or network since the last filing of an access plan with the department, the health carrier shall on October 1 file a statement with the department stating that a change has not been made to the health carrier's managed care plan or network since the date of the most recent previous change to the managed care plan or network. If the health carrier has made a material change to a managed care plan or network, the health carrier shall file an updated access plan with the department whenever the material change is made.

NEW SECTION. **Section 19. Provider responsibility for care -- contracts -- prohibited collection practices.** (1) A health carrier offering a managed care plan shall establish a mechanism by which a participating provider will be notified on an ongoing basis of the covered health care services for which the participating provider is responsible, including any limitations or conditions on those health care services.

(2) A contract between a health carrier and a participating provider must set forth a hold harmless provision specifying protection for covered persons. This requirement is met by including in a contract a provision substantially the same as the following:

"The provider agrees that the provider may not for any reason, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or have any recourse from or against a covered person or a person other than the health carrier or intermediary acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person. This agreement does not prohibit a provider, except a health care professional who is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue services solely at the expense of the covered person if the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available for obtaining payment for services from the health carrier."

(3) A contract between a health carrier and a participating provider must state that if a health carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered persons will continue through the end of the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an inpatient facility on the date of insolvency or other cessation of operations must be continued by a provider until the confinement in an inpatient facility is no longer medically necessary.

(4) The contract provisions that satisfy the requirements of subsections (2) and (3) must be construed in favor of the covered person, survive the termination of the contract regardless of the reason

for termination, including the insolvency of the health carrier, and supersede an oral or written contrary agreement between a participating provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by subsections (2) and (3).

(5) A participating provider may not collect or attempt to collect from a covered person money owed to the provider by the health carrier.

NEW SECTION. **Section 20. Selection of providers -- professional credentials standards.** (1) A health carrier shall adopt standards for selecting participating providers who are primary care professionals and for each health care professional specialty within the health carrier's network. The health carrier shall use the standards to select health care professionals, the health carrier's intermediaries, and any provider network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow the health carrier to:

(a) avoid high-risk populations by excluding a provider because the provider is located in a geographic area that contains populations or providers presenting a risk of higher than average claims, losses, or use of health care services; or

(b) exclude a provider because the provider treats or specializes in treating populations presenting a risk of higher than average claims, losses, or use of health care services.

(2) Subsections (1)(a) and (1)(b) do not prohibit a health carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 18 through 26] and the rules implementing [sections 18 through 26].

(3) [Sections 18 through 26] do not require a health carrier, its intermediary, or a provider network with which the health carrier or its intermediary contract to employ specific providers or types of providers who may meet their selection criteria or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

(4) The department shall adopt rules containing professional credentials standards for participating providers. A health carrier shall verify to the department that a provider used by the health carrier meets the minimum standards set by the department. The minimum standards may include standards related to:

(a) a current license to practice in Montana and history of licensure;

(b) professional liability coverage;

(c) hospital privileges;

(d) the status of specialty board certification;

(e) a drug enforcement agency registration certificate, if applicable;

(f) the completion of graduate and postgraduate training; and

(g) other considerations determined by the department to be necessary to ensure that participating providers meet minimum levels of professional qualification.

(5) A health carrier may use criteria in addition to the minimum credentials standards of the department to select health care professionals allowed to participate in the health carrier's managed care plan. A health carrier shall make its selection standards for participating providers available for review by the department and by each health care professional who is subject to the credentialing verification process.

NEW SECTION. **Section 21. Health carriers -- general responsibilities.** (1) A health carrier offering a managed care plan shall notify participating providers of the participating providers' responsibilities concerning the health carrier's administrative policies and programs, including but not limited to payment terms, utilization review, the quality assurance program, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and applicable federal or state requirements.

(2) A health carrier may not offer an inducement under a managed care plan to a participating provider to provide less than medically necessary services to a covered person.

(3) A health carrier may not prohibit a participating provider from discussing a treatment option with a covered person or from advocating on behalf of a covered person within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

(4) A health carrier shall require a participating provider to make health records available to appropriate state and federal authorities, in accordance with the applicable state and federal laws related to the confidentiality of medical or health records, involved in assessing the quality of care or investigating a grievance or complaint of a covered person.

(5) A health carrier and participating provider shall provide at least 90 days' written notice to each other before terminating the contract between them without cause. The health carrier shall make a good faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a notice of termination from or to a participating provider, to all covered persons who are patients seen on a regular basis by the participating provider whose contract is terminating, irrespective of whether the

termination is for cause or without cause. If a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional must be notified. Within 5 working days of a date that a participating provider either gives or receives notice of termination, the participating provider shall give the health carrier a list of those patients of the participating provider who are covered by a managed care plan of the health carrier.

(6) The rights and responsibilities under a contract between a health carrier and a participating provider may not be assigned or delegated by the participating provider without the prior written consent of the health carrier.

(7) A health carrier shall ensure that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser or as a participant in a publicly financed program of health care services. This requirement does not apply to circumstances in which the participating provider should not render services because of the participating provider's lack of training, experience, or skill or because of a restriction on the participating provider's license.

(8) A health carrier shall notify the participating providers of their obligation, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage or of the participating providers' obligations, if any, to notify covered persons of the covered persons' personal financial obligations for noncovered benefits.

(9) A health carrier may not penalize a participating provider because the participating provider, in good faith, reports to state or federal authorities an act or practice by the health carrier that may adversely affect patient health or welfare.

(10) A health carrier shall establish a mechanism by which a participating provider may determine in a timely manner whether or not a person is covered by the health carrier.

(11) A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between the health carrier and participating providers.

(12) A contract between a health carrier and a participating provider may not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or [sections 11 through 35].

NEW SECTION. **Section 22. Emergency services.** (1) A health carrier offering a managed care plan

shall provide or pay for emergency services screening and emergency services and may not require prior authorization for either of those services. If an emergency services screening determines that emergency services or emergency services of a particular type are unnecessary for a covered person, emergency services or services of the type determined unnecessary by the screening need not be covered by the health carrier unless otherwise covered under the health benefit plan. However, if screening determines that emergency services or services of a particular type are necessary, those services must be covered by the health carrier. A health carrier shall cover emergency services if the health carrier, acting through a participating provider or other authorized representative, has authorized the provision of emergency services.

(2) A health carrier shall provide or pay for emergency services obtained from a nonnetwork provider within the service area of a managed care plan and may not require prior authorization of those services if use of a participating provider would result in a delay that would worsen the medical condition of the covered person or if a provision of federal, state, or local law requires the use of a specific provider.

(3) If a participating provider or other authorized representative of a health carrier authorizes emergency services, the health carrier may not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item or health care services furnished in reliance on approval unless the approval was based on a material misrepresentation about the covered person's medical condition made by the provider of emergency services.

(4) Coverage of emergency services is subject to applicable coinsurance, copayments, and deductibles.

(5) For postevaluation or poststabilization services required immediately after receipt of emergency services, a health carrier shall provide access to an authorized representative 24 hours a day, 7 days a week, to facilitate review.

NEW SECTION. **Section 23. Use of intermediaries -- responsibilities of health carriers, intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions of [sections 11 through 35], and contracting with an intermediary for all or some of the services for which a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

(2) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of [sections 18 through 26].

(3) A health carrier may determine whether a subcontracted provider participates in the provider's own or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(4) A health carrier shall maintain copies of all intermediary health care subcontracts at the health carrier's principal place of business in this state or ensure that the health carrier has access to all intermediary subcontracts, including the right to make copies of the contracts, upon 20 days' prior written notice from the health carrier.

(5) If required in a contract or otherwise by a health carrier, an intermediary shall transmit utilization documentation and claims-paid documentation to the health carrier. The health carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons. This duty may not be delegated to an intermediary by a health carrier.

(6) If required in a contract or otherwise by a health carrier, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the state and preserve them for 5 years in a manner that facilitates regulatory review.

(7) An intermediary shall allow the commissioner, department, board, and council access to the intermediary's books, records, claim information, billing information, and other documentation of services provided to covered persons that are required by any of those entities to determine compliance with [sections 18 through 26] and the rules implementing [sections 18 through 26].

(8) A health carrier may, in the event of the intermediary's insolvency, require the assignment to the health carrier of the provisions of a participating provider's contract addressing the participating provider's obligation to furnish covered benefits.

NEW SECTION. **Section 24. Contract filing requirements -- material changes -- state access to contracts.** (1) On October 1, 1998, a health carrier offering a managed care plan shall file with the department sample contract forms proposed for use with its participating providers and intermediaries.

(2) A health carrier shall file with the department a material change to a contract. The change must be filed with the department at least 60 days before use of the proposed change. A change in a participating provider payment rate, coinsurance, copayment, or deductible or other plan benefit is not considered a material change for the purpose of this subsection.

(3) A health carrier shall maintain participating provider and intermediary contracts at its principal place of business in this state, or the health carrier must have access to all contracts and provide copies to the department upon 20 days' prior written notice from the department.

NEW SECTION. **Section 25. General contracting requirements.** (1) The execution of a contract for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty to provide health care services to a person with whom the health carrier has contracted and does not relieve the health carrier of its responsibility for compliance with [sections 11 through 35] or the rules implementing [sections 11 through 35].

(2) All contracts by a health carrier for the provision of health care services by a managed care plan must be in writing and are subject to review by the department and the commissioner.

NEW SECTION. **Section 26. Contract compliance dates.** (1) A contract between a health carrier and a participating provider or intermediary in effect on October 1, 1997, must comply with [sections 18 through 26] and the rules implementing [sections 18 through 26] by April 1, 1999. The board may extend the April 1 date for an additional period of up to 6 months if the health carrier demonstrates good cause for an extension.

(2) A contract between a health carrier and a participating provider or intermediary issued or put into effect on or after April 1, 1998, must comply with [sections 18 through 26] and the rules implementing [sections 18 through 26] on the day that it is issued or put into effect.

(3) A contract between a health carrier and a participating provider or intermediary not described in subsection (1) or (2) must comply with [sections 18 through 26] and the rules implementing [sections 18 through 26] by April 1, 1999.

NEW SECTION. **Section 27. Department rules.** The department shall adopt rules to implement [sections 18 through 26].

NEW SECTION. **Section 28. Quality assurance -- national accreditation.** (1) A health carrier whose managed care plan has been accredited by a nationally recognized accrediting organization shall annually provide a copy of the accreditation and the accrediting standards used by the accrediting

organization to the department.

(2) If the department finds, in consultation with the council, that the standards of a nationally recognized accrediting organization meet or exceed state standards and that the health carrier has been accredited by the nationally recognized accrediting organization, the department shall approve the quality assurance standards of the health carrier.

(3) The board shall maintain a list of accrediting organizations whose standards have been determined by the department to meet or exceed state quality assurance standards.

(4) [Section 29] does not apply to a health carrier's managed care plan if the health carrier maintains current accreditation by a nationally recognized accrediting organization whose standards meet or exceed state quality assurance standards adopted pursuant to [sections 28 through 34].

(5) This section does not prevent the department from monitoring a health carrier's compliance with [sections 28 through 34].

NEW SECTION. **Section 29. Standards for health carrier quality assessment programs.** A health carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure systems sufficient to accurately measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this requirement, a health carrier shall:

(1) establish and use a system designed to assess the quality of health care provided to covered persons and appropriate to the types of plans offered by the health carrier. The system must include systematic collection, analysis, and reporting of relevant data.

(2) communicate in a timely fashion its findings concerning the quality of health care to regulatory agencies, providers, and consumers as provided in [section 32];

(3) report to the appropriate professional or occupational licensing board provided in Title 37 any persistent pattern of problematic care provided by a participating provider that is sufficient to cause the health carrier to terminate or suspend a contractual arrangement with the participating provider; and

(4) file a written description of the quality assessment program with the department in a format that must be prescribed by rules of the department. The description must include a signed certification by a corporate officer of the health carrier that the health carrier's quality assessment program meets the requirements of [sections 28 through 34].

NEW SECTION. **Section 30. Standards for health carrier quality improvement programs.** A health carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 29], adopt and use systems and methods necessary to improve the quality of health care provided in the health carrier's managed care plan as indicated by the health carrier's quality assessment program and as required by this section. In order to comply with this requirement, a health carrier subject to this section shall:

(1) establish an internal system capable of identifying opportunities to improve care. The system must be structured to:

(a) identify practices that result in improved health care outcomes;

(b) identify problematic utilization patterns;

(c) identify those participating providers that may be responsible for either exemplary or problematic patterns; and

(d) foster an environment of continuous quality improvement.

(2) use the findings generated by the system required by subsection (1) to work on a continuing basis with participating providers and other staff within the closed plan or closed component to improve the health care delivered to covered persons;

(3) adopt and use a program for designing, measuring, assessing, and improving the processes and outcomes of health care as identified in the health carrier's quality improvement program plan that must be filed with the department and that must be consistent with [sections 28 through 34]. The program must be under the direction of the chief medical officer or clinical director of the health carrier. The program must include:

(a) a written statement of the objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, performance improvement activities, and annual effectiveness review of the quality improvement program;

(b) a written quality improvement plan that describes how the health carrier intends to:

(i) analyze both health care processes and outcomes of health care, including focused review of individual cases as appropriate, to discern the causes of any variation;

(ii) identify health care diagnoses and treatments to be reviewed by the quality improvement program each year. In determining which diagnoses and treatments to review, the health carrier shall consider diagnoses and treatments that affect a substantial number of the plan's covered persons or that could place covered persons at serious risk. This subsection (3)(b)(ii) does not require a health carrier to

review every disease, illness, and condition that may affect a member of a managed care plan offered by the health carrier.

(iii) use a range of appropriate methods to analyze quality of health care, including:

(A) collection and analysis of information on overutilization and underutilization of health care services;

(B) evaluation of courses of treatment and outcomes of health care, including health status measures, consistent with reference data bases, such as current medical research, knowledge, standards, and practice guidelines; and

(C) collection and analysis of information specific to a covered person or provider that has been gathered from multiple sources, such as utilization management, claims processing, and documentation of both the satisfaction and grievances of covered persons;

(iv) compare program findings with past performance, as appropriate, and with internal goals and external standards, when available, adopted by the health carrier;

(v) measure the performance of and conduct peer review activities for participating providers, such as by:

(A) identifying health care practices that do not meet the health carrier's standards;

(B) taking appropriate action to correct deficiencies;

(C) monitoring participating providers to determine whether they have implemented corrective action; and

(D) taking appropriate action when the participating provider has not implemented corrective action;

(vi) make use of:

(A) treatment protocols and practice parameters developed with appropriate clinical input;

(B) the evaluations described in subsections (3)(b)(i) and (3)(b)(ii); or

(C) acquired treatment protocols developed with appropriate clinical input;

(vii) provide participating providers with sufficient information about the protocols referred to in subsections (3)(b)(vi)(A) and (3)(b)(vi)(C) to enable participating providers to meet the standards established by the protocols;

(viii) evaluate access to care for covered persons according to the standards provided in [section 18] and the rules adopted by the board. The quality improvement plan required by this subsection (3)(b) must describe the health carrier's strategy for integrating public health goals with health care services

offered to covered persons under the managed care plans of the health carrier, including a description of the health carrier's efforts to initiate or maintain communication with public health agencies.

(ix) implement improvement strategies in response to quality assessment findings that indicate improvement is needed;

(x) evaluate periodically, but not less than annually, the effectiveness of the strategies implemented pursuant to subsection (3)(b)(ix);

(xi) ensure that participating providers have the opportunity to participate in developing, implementing, and evaluating the health carrier's quality improvement program; and

(xii) provide covered persons the opportunity to comment on the health carrier's quality improvement program.

NEW SECTION. **Section 31. Corporate oversight -- responsibilities of chief medical officer and health carrier.** (1) The chief medical officer or clinical director of a health carrier offering a closed plan or a combination plan has primary responsibility for the quality assurance activities carried out by or on behalf of the health carrier and for ensuring that the requirements of [sections 28 through 34] are met. The chief medical officer or clinical director shall:

(a) approve the written quality assurance program implemented in compliance with [sections 28 through 34];

(b) periodically review and revise the written description of the quality assessment program filed with the department pursuant to [section 29(4)] and the quality improvement plan filed with the department pursuant to [section 30(3)]; and

(c) act to ensure ongoing compliance with [sections 28 through 34].

(2) Not less than semiannually, the chief medical officer or clinical director shall review reports of quality assurance activities.

(3) The health carrier is responsible for the actions of the chief medical officer or clinical director carried out on behalf of the health carrier and for ensuring that all requirements of [sections 28 through 34] are met.

NEW SECTION. **Section 32. Reporting and disclosure requirements.** (1) A health carrier offering a closed plan or a combination plan shall document and communicate information, as required in this

section, about its quality assurance program. The health carrier shall:

(a) include a summary of its quality assurance program in marketing materials;

(b) include a description of its quality assurance program and a statement of patient rights and responsibilities with respect to that program in the certificate of coverage or handbook provided to newly enrolled covered persons; and

(c) make available annually to providers and covered persons a report containing findings from its quality assurance program and information about its progress in meeting internal goals and external standards, when available. The report must include a description of the methods used to assess each specific area and an explanation of how any assumptions affect the findings.

(2) A health carrier shall certify to the department annually that its quality assurance program and the materials provided to providers and consumers in accordance with subsection (1) meet the requirements of [sections 28 through 34].

(3) A health carrier shall make available upon request and payment of a reasonable fee the materials certified pursuant to subsection (2), except for the materials subject to the confidentiality requirements of [section 33] and materials that are proprietary to the health plan. A health carrier shall retain all certified materials for at least 3 years from the date that the material was certified or until the material has been examined as part of a market conduct examination, whichever is later.

NEW SECTION. **Section 33. Confidentiality of health care and quality assurance records -- disclosure.** (1) Except as provided in subsection (2), the following information held by a health carrier offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a person:

(a) information pertaining to the diagnosis, treatment, or health of a covered person, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer retrievable form;

(b) information considered by a quality assurance program and the records of its actions, including testimony of a member of a quality committee; of an officer, director, or other member of a health carrier or its staff engaged in assisting the quality committee or engaged in the health carrier's quality assessment, quality improvement, or quality assurance activities; or of any person assisting or furnishing information to the quality committee.

(2) The information specified in subsection (1) may be disclosed:

(a) as allowed by Title 33, chapter 19;

(b) as required in proceedings before the commissioner, a professional or occupational licensing board provided in Title 37, or the department pursuant to Title 50, chapter 5, part 2;

(c) in an appeal, if an appeal is permitted, from a quality committee's findings or recommendations; or

(d) as otherwise required by law or court order, including a judicial or administrative subpoena.

(3) Information specified in subsection (1) identifying:

(a) the provider may also be disclosed upon a written, dated, and signed approval of the provider if the information does not identify the covered person;

(b) the covered person may also be disclosed upon a written, dated, and signed approval of the covered person or of the parent or guardian of a covered person if the covered person is a minor and if the information does not identify the provider.

(c) neither the provider nor the covered person may also be disclosed upon request for use for statistical purposes only.

NEW SECTION. **Section 34. Contracted quality assurance functions -- health carrier responsibility.** If a health carrier contracts to have another entity perform the quality assessment, quality improvement, or quality assurance functions required by [sections 28 through 34] and the rules implementing [sections 28 through 34], the health carrier shall monitor the activities of the entity with which the health carrier contracts and ensure that the requirements of [sections 28 through 34] and the rules implementing [sections 28 through 34] are met.

NEW SECTION. **Section 35. Enforcement.** (1) If the department or the council determines that a health carrier has not complied with [sections 11 through 35] or the rules implementing [sections 11 through 35], the council may recommend corrective action to the health carrier.

(2) The commissioner may take the enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the council;

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with [sections 11 through 35] and the rules implementing [sections 11 through 35] within a

reasonable period of time;

(c) the board demonstrates to the commissioner that a health carrier does not comply with [sections 11 through 35] or the rules implementing [sections 11 through 35]; or

(d) the commissioner determines that a health carrier has violated or is violating [sections 11 through 35] or the rules implementing [sections 11 through 35].

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with [sections 11 through 35] or the rules implementing [sections 11 through 35]:

(a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's application for a certificate of authority; or

(b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part 3.

NEW SECTION. **Section 36. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 2, chapter 15, and the provisions of Title 2, chapter 15, apply to [sections 1 and 2].

(2) [Section 10] is intended to be codified as an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 10].

(3) [Sections 11 through 35] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 11 through 35].

NEW SECTION. **Section 37. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 38. Applicability.** [This act] applies to a health carrier as defined in [section 13], who offers a managed care plan as defined in [section 13], on or after [the effective date of this section].

NEW SECTION. **Section 39. Effective dates.** (1) Except as provided in subsections (2) through

(4), [this act] is effective October 1, 1997.

(2) [Sections 36 through 38 and this section] are effective on passage and approval.

(3) [Sections 1, 2, and 11 through 17] are effective July 1, 1997.

(4) [Sections 28 through 34] are effective October 1, 1998.

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0128, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:

A bill providing for the regulation of health insurance carriers who offer managed care plans to assure that services provided through managed health care plans in Montana are adequate, accessible and meet quality standards.

ASSUMPTIONS:

1. The Board of Network Adequacy and Quality Assurance will be established July 1, 1997, and will be attached to the Department of Public Health and Human Services (PHHS) for administration. There will be no costs associated with the board meetings.
2. The Network and Quality Review Council will meet in Helena six times in FY98 and four times in FY99. Each meeting will cost $1,200 taking into account: fees, per diem and travel costs.
3. The medical director required by this bill will be contracted for 300 hours per year at $100/hr for a total yearly contract cost of $30,000.
4. Staffing and assistance for the board and council will be provided by PHHS. They will require 1.50 FTE registered nurses in FY98 with another added in FY99. The cost of a grade 16 position is $37,200 per year.
5. The State Auditor's Office (SAO) will require a .50 FTE nursing position to provide professional assistance and expertise. In addition, the SAO will need a 1.00 FTE compliance specialist to handle additional complaints that will be created by the passage of this bill. The .50 FTE nurse will cost $18,600/year, with the compliance specialist being $31,800.
6. Operating expenses for each employee is estimated to be $4,300/year, and equipment is $4,000 per employee.
7. PHHS will also need to contract for health system analysis and program assistance at a cost of $32,000/year. In addition, rule drafting and writing will require 120 hours of legal assistance at $53/hour, or $6,400.
8. It is estimated that 15% of the regulated HMOs will be Medicaid HMOs and that federal matching Medicaid funds will be available for this portion of the costs. The federal match rate is 75% for medical personnel (medical director and RNs) and 50% for other admin costs.

FISCAL IMPACT:

Expenditures:

DPHHS:	FY98 Difference	FY99 Difference
FTE	1.50	2.50
Personal Services	$55,800	$ 93,000
Operating Expenses	82,000	77,500
Equipment	6,000	4,000
Total	$143,800	$174,500

Funding:

General Fund (01)	$128,800	$157,000
Federal (03)	14,000	17,500
Total	$143,800	$174,500

(Continued)

Dave Lewis 1-13-97

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Don Hargrove 1-13-97

DON HARGROVE, PRIMARY SPONSOR DATE

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0128, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:

A bill providing for the regulation of health insurance carriers who offer managed care plans to assure that services provided through managed health care plans in Montana are adequate, accessible and meet quality standards.

ASSUMPTIONS:

1. The Board of Network Adequacy and Quality Assurance will be established July 1, 1997, and will be attached to the Department of Public Health and Human Services (PHHS) for administration. There will be no costs associated with the board meetings.
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Federal (03)	14,000	17,500
Total	$143,800	$174,500

(Continued)

Dave Lewis 1-14-97

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Don Hargrove

DON HARGROVE, PRIMARY SPONSOR DATE

Revised-SB 128 #2

Expenditures:

State Auditor's Office:	FY98 Difference	FY99 Difference
FTE	.50	1.50
Personal Services	$18,600	$ 50,400
Operating Expenses	2,000	6,000
Equipment	4,000	4,000
Total	$24,600	$ 60,400

Funding:

General Fund (01)	$24,600	$60,400

Net Impact on Fund Balance: (Revenue minus expense)

General Fund (01)	($153,400)	($217,400)
Federal Special (03)	(14,000)	(17,500)
Total	($167,400)	($234,900)