BILL NO. 365

INTRODUCED BY BENEDICT HARP MERCER

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; 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; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS 33-22-1703, 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 [sections 12, 13, and 22] require rules to be adopted by the department of public health and human services.

The rules adopted by the department must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 8 through 29] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 8 through 29].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 8 through 29], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of 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 standards that are at least the equivalent of health plan employer data and information standards. Any other standards adopted must be appropriate for quality assurance in Montana.

The department may refer reports of noncompliance by a health carrier to the commissioner for corrective action. Under the department's rulemaking authority, the department shall specify network

adequacy and quality assurance review processes.

[Section 19] 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 and quality assurance.

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

Section 1. Section 33-22-1703, MCA, is amended to read:

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

(1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(2) "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.~~ health care items or services furnished or required to evaluate and treat an emergency medical condition.

~~(2)~~(3) "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)~~(4) "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)~~ 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)~~(5) "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)~~(6) "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)~~(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

~~(7)~~(8) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider.

~~(8)~~(9) "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)~~(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

Section 2. Section 33-22-1707, MCA, is amended to read:

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

Section 3. 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~~ advanced practice registered nurse 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 4. Section 33-31-111, MCA, is amended to read:

"33-31-111. **Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to 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 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 8 through 29]."

Section 5. 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 required of the commissioner under 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 6. 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:~~

~~(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~~ is $200,000.

(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 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 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 7. 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 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care Plan Network Adequacy and Quality Assurance Act".

NEW SECTION. **Section 9. Purpose.** The purpose and intent of [sections 8 through 29] 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 implementation of 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. It is not the purpose or intent of [sections 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

NEW SECTION. **Section 10. Definitions.** As used in [sections 8 through 29], the following definitions apply:

(1) "Closed plan" means a managed care plan that requires covered persons to use only

participating providers under the terms of the managed care plan.

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

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

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

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

(6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

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

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

(9) "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.

(10) "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.

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

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

(13) "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.

(14) "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.

(15) "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, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(16) "Medically necessary" means services or supplies that are necessary and appropriate for the treatment of a covered person's emergency medical condition or for the preventive care of a covered person according to accepted standards of medical practice.

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

(18) "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.

(19) "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.

(20) "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.

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

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

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

NEW SECTION. **Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health carriers that offer managed care plans. [Sections 8 through 29] 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 12. Department -- general powers and duties -- rulemaking.** (1) The department 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 department.

(2) Quality assurance standards adopted by the department must consist of some but not all of the health plan employer data and information standards. The department shall select and adopt only standards appropriate for quality assurance in Montana.

(3) The state may contract, through a competitive bidding process, for the development of network adequacy and quality assurance standards.

NEW SECTION. **Section 13. 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. A health carrier shall file any subsequent material changes in its access plan with the department within 30 days of implementation of the change.

(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 department to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

NEW SECTION. **Section 14. Provider responsibility for care -- contracts -- prohibited collection practices.** (1) A health carrier offering a managed care plan shall establish a mechanism, described in detail in the contract, 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, but not to exceed 30 days, 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 15. 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) Subsection (1) does 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 13 through 21] and the rules implementing [sections 13 through 21].

(3) [Sections 13 through 21] 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) A health carrier may use criteria established in accordance with the provisions of this section 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 selection standards.

NEW SECTION. **Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering a managed care plan shall notify, in writing, prospective participating providers of the participating providers' responsibilities concerning the health carrier's administrative policies and programs, including but not limited to payment terms, utilization reviews, 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, when the authorities are 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 60 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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.

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

(11) 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 8 through 29].

(12) A contract between a health carrier and a participating provider shall set forth all of the responsibilities and obligations of the provider either in the contract or documents referenced in the contract. A health carrier shall make its best effort to furnish copies of any reference documents, if requested by a participating provider, prior to execution of the contract.

NEW SECTION. **Section 17. 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 emergency 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 emergency 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 18. Use of intermediaries -- responsibilities of health carriers, intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions of [sections 8 through 29], 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) A health carrier may determine whether a subcontracted provider participates in the provider's own network or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(3) 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.

(4) 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.

(5) 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.

(6) An intermediary shall allow the department 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 13 through 21] and the rules implementing [sections 13 through 21].

(7) 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 19. 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 20. 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 8 through 29] or the rules implementing [sections 8 through 29].

(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 21. 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 13 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department 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 13 through 21] and the rules implementing [sections 13 through 21] 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 w th [sections 13 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999.

NEW SECTION. **Section 22. Department rules.** The department shall adopt rules to implement [sections 13 through 21].

NEW SECTION. **Section 23. 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 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 department 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 24] 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 23 through 27].

(5) This section does not prevent the department from monitoring a health carrier's compliance with [sections 23 through 27].

NEW SECTION. **Section 24. 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 26];

(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 and any subsequent material changes 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 23 through 27].

NEW SECTION. **Section 25. 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 24], 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. 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;

(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 measuring, assessing and improving the outcomes of health care as identified in the health carrier's quality improvement program plan. This quality improvement program plan must be filed with the department by October 1, 2000, and must be consistent with [sections 23 through 27]. A health carrier shall file any subsequent material changes to its quality improvement program plan within 30 days of implementation of the change. The quality improvement program plan must:

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

(b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to subsection (3)(a).

NEW SECTION. **Section 26. 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.

(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 23 through 27].

(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 27] and materials that are proprietary to the managed care 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 27. 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 28. Enforcement.** (1) If the department determines that a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the department may recommend corrective action to the health carrier.

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

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

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with [sections 8 through 29] and the rules implementing [sections 8 through 29] within a reasonable period of time;

(c) the department demonstrates to the commissioner that a health carrier does not comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]; or

(d) the commissioner determines that a health carrier has violated or is violating [sections 8 through 29] or the rules implementing [sections 8 through 29].

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]:

(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 29. Jurisdiction over contract actions.** The district courts have jurisdiction over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

NEW SECTION. **Section 30. Codification instruction.** (1) [Section 7] 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 7].

(2) [Sections 8 through 29] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 8 through 29].

NEW SECTION. **Section 31. 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 32. Applicability.** [This act] applies to a health carrier as defined in [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of this section].

NEW SECTION. **Section 33. Effective dates.** (1) Except as provided in subsections (2) and (3), [this act] is effective January 1, 1998.

(2) [Sections 22 and 30 through 32 and this section] are effective on passage and approval.

(3) [Sections 23 through 26] are effective October 1, 1999.

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0365, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:
An act providing for the regulation of health insurance carriers who offer managed care plans, providing for state network adequacy and quality assurance standards.

ASSUMPTIONS:
Department of Public Health and Human Services (DPHHS):

1. DPHHS arranges for professional medical consultants to assist with the adoption of quality assurance standards.
2. This group of five consultants will meet six times in fiscal 1998 and four times in fiscal 1999.
3. Fees, per diem, and travel costs are estimated to be $745 per meeting. MetNet costs are estimated at $4,000 per year.
4. A Medical Director is contracted for 300 hours per year at $100/hr for a total yearly contract cost of $30,000.
5. Registered nurses (grade 16) will be needed during fiscal 1998 (1.00 FTE) and fiscal 1999 (1.00 additional FTE). The cost for a grade 16 FTE is $34,640 including benefits. That brings personal services costs to $34,640 in fiscal 1998 and $69,280 in fiscal 1999.
6. Operating expense per FTE is estimated at $2,500 per year plus travel of $1,800 per year for a total per FTE per year of $4,300.
7. Equipment costs for each FTE the first year include a PC and office equipment at a cost of $4,000.
8. An estimated 120 hours of legal assistance in rule drafting will be required in the first year at a cost of $53.00/hour for total legal costs of $6,360.
9. Contract funds for a health systems analysis and program assistance will total $32,000 per year.
10. 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 listed above. The federal match rate is 75% for medical personnel (Medical Director and RNs) and 50% for other administrative costs.

State Auditor:

11. The State Auditor's Office (SAO) will receive referrals from the DPHHS regarding complaints related to network adequacy and quality assurance. SAO will take appropriate enforcement actions with existing staff.
12. Growth in Health Management Organizations (HMOs) will generate an increase in the number of complaints to the Policyholder Services Bureau. HMOs restrict the number of options available to the HMO members. This will increase complaints requiring the SAO to add a 1.00 FTE compliance specialists, grade 14, to handle these complaints.

FISCAL IMPACT:

Department of Public Health and Human Services

Expenditures:	FY98 Difference	FY99 Difference
FTE	1.00	2.00
Personal Services	$ 34,640	$ 68,280
Operating Expenses	81,130	77,580
Equipment	4,000	4,000
Total	$122,470	$156,260
Funding:		
General Fund (01)	$110,760	$140,615
Federal Medicaid Funds (03)	11,710	15,645
Total	$122,470	$156,260

(Continued)

Dave Lewis 2-19-97
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Steve Benedict 2/20/97
STEVE BENEDICT, PRIMARY SPONSOR DATE

State Auditor

Expenditures:	FY98 Difference	FY99 Difference
FTE	0.00	1.00
Personal Services		$ 31,835
Operating Expenses		4,000
Equipment	0	3,585
Total	$ 0	$ 39,420
Funding:		
General Fund (01)	0	$ 39,420
Net Impact on Fund Balance:	(Revenue minus Expenses)	
General Fund (01)	($110,760)	($180,035)

SENATE BILL NO. 365

INTRODUCED BY BENEDICT, HARGROVE, GRIMES, HARP, MERCER, AKLESTAD, AHNER, GROSFIELD, MASOLO, BAER, M. TAYLOR, MILLS, ROSE, MAHLUM, MOOD, SPRAGUE, JABS, ESTRADA, DEPRATU, FOSTER, MCNUTT, KEATING, JENKINS, CRISMORE, GLASER, HERTEL, BURNETT, THOMAS, SMITH, CRIPPEN, COLE, BOHLINGER, PECK, DENNY, OHS, GRINDE, BOOKOUT-REINICKE, BARNETT, MARSHALL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; 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; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD; AMENDING SECTIONS 33-22-1703, 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, AND A TERMINATION DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 12, 13, and 22] require rules to be adopted by the department of public health and human services.

The rules adopted by the department must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 8 through 29] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 8 through 29].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 8 through 29], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of 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 standards that are ~~at least the equivalent of health plan employer data and information standards. Any other standards adopted must be~~ appropriate for quality assurance in Montana.

The department AND SUBSEQUENTLY 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 department's rulemaking authority, the department shall specify network adequacy and quality assurance review processes.

[Section 19] 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 and quality assurance.

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

Section 1. Section 33-22-1703, MCA, is amended to read:

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

(1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(2) "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.~~ health care items or services furnished or required to evaluate and treat an emergency medical condition.

~~(2)~~(3) "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)~~(4) "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)~~ 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)~~(5) "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)~~(6) "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)~~(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

~~(7)~~(8) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider.

~~(8)~~(9) "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)~~(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

Section 2. Section 33-22-1707, MCA, is amended to read:

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

Section 3. 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. THIS TERM APPLIES TO PROVIDER-SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING COOPERATIVES.

(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~~ advanced practice registered nurse 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) "PROVIDER-SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS, HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A PHYSICIAN-HOSPITAL ORGANIZATION, A PHYSICIAN-SPONSORED NETWORK, A PHYSICIAN GROUP PRACTICE, AND A HOSPITAL-PHYSICIAN ORGANIZATION.

~~(12)~~(13) "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 4. Section 33-31-111, MCA, is amended to read:

"**33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to 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 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 8 through 29]."

Section 5. 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 required of the commissioner under 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 6. 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:~~

~~(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~~ is $200,000.

(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 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 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 7. 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 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care Plan Network Adequacy and Quality Assurance Act".

NEW SECTION. **Section 9. Purpose.** The purpose and intent of [sections 8 through 29] 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 implementation of 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 COORDINATED EFFORTS OF THE COMMISSIONER AND THE DEPARTMENT [AND THE BOARD]. It is not the purpose or intent of [sections 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

NEW SECTION. **Section 10. Definitions.** As used in [sections 8 through 29], the following definitions apply:

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

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

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

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

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

(6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

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

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

(9) "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.

(10) "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.

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

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

(13) "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.

(14) "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.

(15) "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, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(16) "Medically necessary" means services or supplies that are necessary and appropriate for the treatment of a covered person's emergency medical condition or for the preventive care of a covered person according to accepted standards of medical practice.

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

(18) "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.

(19) "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.

(20) "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.

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

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

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

NEW SECTION. **Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health carriers that offer managed care plans. [Sections 8 through 29] 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 12. Department -- general powers and duties -- rulemaking.** (1) The department 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 [OR TO THE BOARD] against a health carrier whose managed care plan does not comply with standards for network adequacy and quality assurance adopted

by the department.

(2) Quality assurance standards adopted by the department must consist of some but not all of the health plan employer data and information standards. The department shall select and adopt only standards appropriate for quality assurance in Montana.

(3) The state may contract, through a competitive bidding process, for the development of network adequacy and quality assurance standards.

NEW SECTION. **Section 13. 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)~~(4) 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)~~ (6) 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)~~ (6) 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. A health carrier shall file any subsequent material changes in its access plan with the department within 30 days of implementation of the change.

~~(6)~~(5) 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)~~(6) 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 department to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

(7) THE DEPARTMENT SHALL ENSURE TIMELY AND EXPEDITED REVIEW AND APPROVAL OF THE ACCESS PLAN AND OTHER REQUIREMENTS IN THIS SECTION.

NEW SECTION. **Section 14. Provider responsibility for care -- contracts -- prohibited collection practices.** ~~(1) A health carrier offering a managed care plan shall establish a mechanism, described in detail in the contract, 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)~~(1) 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)~~(2) 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, but not to exceed 30 days, 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)~~(3) The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2) 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)~~ (1) AND (2).

~~(5)~~(4) 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 15. 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) Subsection (1) does 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 13 through 21] and the rules implementing [sections 13 through 21].

(3) [Sections 13 through 21] 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) A health carrier may use criteria established in accordance with the provisions of this section 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 selection standards.

NEW SECTION. **Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering a managed care plan shall notify, in writing, prospective participating providers of the participating providers' responsibilities concerning the health carrier's administrative policies and programs, including but not limited to payment terms, utilization reviews, 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, when the authorities are 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 60 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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.

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

(11) 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 8 through 29].

(12) A contract between a health carrier and a participating provider shall set forth all of the responsibilities and obligations of the provider either in the contract or documents referenced in the contract. A health carrier shall make its best effort to furnish copies of any reference documents, if requested by a participating provider, prior to execution of the contract.

NEW SECTION. **Section 17. 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 emergency 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 emergency 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 18. Use of intermediaries -- responsibilities of health carriers, intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions of [sections 8 through 29], 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) A health carrier may determine whether a subcontracted provider participates in the provider's

own network or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(3) 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.

(4) 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.

(5) 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.

(6) An intermediary shall allow the COMMISSIONER AND THE department 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 13 through 21] and the rules implementing [sections 13 through 21].

(7) 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 19. 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 20. 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 8 through 29] or the rules implementing [sections 8 through 29].

(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 21. 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 13 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department 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 13 through 21] and the rules implementing [sections 13 through 21] 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 13 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999.

NEW SECTION. **Section 22. Department rules.** The department shall adopt rules to implement [sections 13 through 21].

NEW SECTION. **Section 23. 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 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 department 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 24] 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 23 through 27].

(5) This section does not prevent the department from monitoring a health carrier's compliance with [sections 23 through 27].

NEW SECTION. **Section 24. 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 26];

(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 and any subsequent material changes 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 23 through 27].

NEW SECTION. **Section 25. 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 24], 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. 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;

(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 measuring, assessing and improving the outcomes of health care as identified in the health carrier's quality improvement program plan. This quality improvement program plan must be filed with the department by October 1, 2000, and must be consistent with [sections 23 through 27]. A health carrier shall file any subsequent material changes to its quality improvement program plan within 30 days of implementation of the change. The quality improvement program plan must:

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

(b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to subsection (3)(a).

NEW SECTION. **Section 26. 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.

(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 23 through 27].

(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 27] and materials that are proprietary to the managed care 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 27. 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 28. Enforcement.** (1) If the department [OR THE BOARD] determines that a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the department [OR THE BOARD] may recommend corrective action to the health carrier.

(2) ~~The~~ AT THE RECOMMENDATION OF THE DEPARTMENT [OR THE BOARD] THE commissioner may take an enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the department [OR THE BOARD];

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with [sections 8 through 29] and the rules implementing [sections 8 through 29] within a reasonable period of time;

(c) the department [OR THE BOARD] demonstrates to the commissioner that a health carrier does not comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]; or

(d) the commissioner determines that a health carrier has violated or is violating [sections 8 through 29] or the rules implementing [sections 8 through 29].

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]:

(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 29. Jurisdiction over contract actions.** The district courts have jurisdiction over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

NEW SECTION. **SECTION 30. DEFINITIONS.** AS USED IN [SECTIONS 8 THROUGH 29], THE

FOLLOWING DEFINITIONS APPLY:

(1) "BOARD" MEANS THE BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE PROVIDED FOR IN [SECTION 31].

(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) "COVERED BENEFITS" MEANS THOSE HEALTH CARE SERVICES TO WHICH A COVERED PERSON IS ENTITLED UNDER THE TERMS OF A HEALTH BENEFIT PLAN.

(5) "COVERED PERSON" MEANS A POLICYHOLDER, SUBSCRIBER, OR ENROLLEE OR OTHER INDIVIDUAL PARTICIPATING IN A HEALTH BENEFIT PLAN.

(6) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES ESTABLISHED IN 2-15-2201.

(7) "EMERGENCY MEDICAL CONDITION" MEANS A CONDITION MANIFESTING ITSELF BY SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN ANY OF THE FOLLOWING:

(A) THE COVERED PERSON'S HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) THE COVERED PERSON'S BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(8) "EMERGENCY SERVICES" MEANS HEALTH CARE ITEMS AND SERVICES FURNISHED OR REQUIRED TO EVALUATE AND TREAT AN EMERGENCY MEDICAL CONDITION.

(9) "FACILITY" MEANS AN INSTITUTION PROVIDING HEALTH CARE SERVICES OR A HEALTH CARE SETTING, INCLUDING BUT NOT LIMITED TO A HOSPITAL, MEDICAL ASSISTANCE FACILITY, AS DEFINED IN 50-5-101, OR OTHER LICENSED INPATIENT CENTER, AN AMBULATORY SURGICAL OR TREATMENT CENTER, A SKILLED NURSING CENTER, A RESIDENTIAL TREATMENT CENTER, A DIAGNOSTIC, LABORATORY, OR IMAGING CENTER, OR A REHABILITATION OR OTHER THERAPEUTIC HEALTH SETTING.

(10) "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.

(11) "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.

(12) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL OR A FACILITY.

(13) "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION, TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE.

(14) "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.

(15) "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.

(16) "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, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS OPERATED IN A FEE-FOR-SERVICE INDEMNITY ENVIRONMENT.

(17) "MEDICALLY NECESSARY" MEANS SERVICES OR SUPPLIES THAT ARE NECESSARY AND APPROPRIATE FOR THE TREATMENT OF A COVERED PERSON'S EMERGENCY MEDICAL CONDITION OR FOR THE PREVENTIVE CARE OF A COVERED PERSON ACCORDING TO ACCEPTED STANDARDS OF MEDICAL PRACTICE.

(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 SERVICES WITHIN A HEALTH PLAN.

NEW SECTION. **SECTION 31. 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 A SPECIALIST IN EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.

(3) THE GENERAL POWERS AND DUTIES OF THE BOARD ARE PROVIDED IN [SECTION 32].

(4) THE BOARD IS ATTACHED FOR ADMINISTRATIVE PURPOSES TO THE DEPARTMENT PURSUANT TO 2-15-121.

NEW SECTION. **SECTION 32. BOARD -- GENERAL POWERS AND DUTIES.** THE BOARD SHALL:

(1) PERIODICALLY REVIEW THE STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS PROVIDED IN [SECTIONS 8 THROUGH 29] AND THE RULES IMPLEMENTING [SECTIONS 8

THROUGH 29];

(2) RECOMMEND CORRECTIVE ACTION NECESSARY FOR THE HEALTH CARRIER TO ACHIEVE COMPLIANCE WITH STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS; AND

(3) 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.

NEW SECTION. **Section 33. Codification instruction.** (1) [Section 7] 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 7].

(2) [Sections 8 through ~~29~~ 32] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 8 through ~~29~~ 32].

NEW SECTION. **Section 34. 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 35. Applicability.** [This act] applies to a health carrier as defined in [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of this section].

NEW SECTION. **Section 36. Effective dates.** (1) Except as provided in subsections (2) and (3), [this act] is effective January 1, 1998.

(2) [Sections 22 ~~and 30 through 32~~, 33 THROUGH 35, AND 37 and this section] are effective on passage and approval.

(3) [Sections 23 through 26] are effective October 1, 1999.

(4) [SECTIONS 30 THROUGH 32] AND THE LANGUAGE IN BRACKETS IN [SECTIONS 9, 12, AND 28] ARE EFFECTIVE JULY 1, 2001.

NEW SECTION. **SECTION 37. TERMINATION.** [SECTION 10] TERMINATES JUNE 30, 2001.

-END-

SENATE BILL NO. 365

INTRODUCED BY BENEDICT, HARGROVE, GRIMES, HARP, MERCER, AKLESTAD, AHNER, GROSFIELD, MASOLO, BAER, M. TAYLOR, MILLS, ROSE, MAHLUM, MOOD, SPRAGUE, JABS, ESTRADA, DEPRATU, FOSTER, MCNUTT, KEATING, JENKINS, CRISMORE, GLASER, HERTEL, BURNETT, THOMAS, SMITH, CRIPPEN, COLE, BOHLINGER, PECK, DENNY, OHS, GRINDE, BOOKOUT-REINICKE, BARNETT, MARSHALL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; 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; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD; AMENDING SECTIONS 33-22-1703, 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, AND A TERMINATION DATE."

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO SECOND READING COPY (YELLOW) FOR COMPLETE TEXT.

SENATE BILL NO. 365

INTRODUCED BY BENEDICT, HARGROVE, GRIMES, HARP, MERCER, AKLESTAD, AHNER, GROSFIELD, MASOLO, BAER, M. TAYLOR, MILLS, ROSE, MAHLUM, MOOD, SPRAGUE, JABS, ESTRADA, DEPRATU, FOSTER, MCNUTT, KEATING, JENKINS, CRISMORE, GLASER, HERTEL, BURNETT, THOMAS, SMITH, CRIPPEN, COLE, BOHLINGER, PECK, DENNY, OHS, GRINDE, BOOKOUT-REINICKE, BARNETT, MARSHALL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; 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; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; ~~CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;~~ AMENDING SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND PROVIDING EFFECTIVE DATES~~, AND~~ AND AN APPLICABILITY DATE~~, AND A TERMINATION DATE~~."

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 12, 13, and 22] require rules to be adopted by the department of public health and human services.

The rules adopted by the department must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 8 through 29] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 8 through 29].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 8 through 29], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of 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 standards that are ~~at least the equivalent of health plan employer data and information standards. Any other standards adopted must be~~ appropriate for quality assurance in Montana.

The department ~~AND SUBSEQUENTLY 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 department's rulemaking authority, the department shall specify network adequacy and quality assurance review processes.

[Section 19] 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 and quality assurance.

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

Section 1. Section 33-22-1703, MCA, is amended to read:

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

(1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(2) "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.~~ health care items or services furnished or required to evaluate and treat an emergency medical condition.

~~(2)~~(3) "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)~~(4) "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)~~ 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)~~(5) "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)~~(6) "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)~~(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

~~(7)~~(8) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider.

~~(8)~~(9) "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)~~(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

Section 2. Section 33-22-1707, MCA, is amended to read:

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

Section 3. 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. ~~THIS TERM APPLIES TO PROVIDER-SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING COOPERATIVES.~~

(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~~ advanced practice registered nurse 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) "PROVIDER-SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS, HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A PHYSICIAN-HOSPITAL ORGANIZATION, A PHYSICIAN-SPONSORED NETWORK, A PHYSICIAN GROUP PRACTICE, AND A HOSPITAL-PHYSICIAN ORGANIZATION.~~

~~(12)(13)~~(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 4. Section 33-31-111, MCA, is amended to read:

"**33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to 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 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 8 through 29]."

Section 5. 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 required of the commissioner under 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 6. 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:~~

~~(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~~ is $200,000.

(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 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 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 7. 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 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care Plan Network Adequacy and Quality Assurance Act".

NEW SECTION. **Section 9. Purpose.** The purpose and intent of [sections 8 through 29] 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 implementation of 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 COORDINATED EFFORTS OF THE COMMISSIONER AND THE DEPARTMENT ~~[AND THE BOARD]~~. It is not the purpose or intent of [sections 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

NEW SECTION. **Section 10. Definitions.** As used in [sections 8 through 29], the following definitions apply:

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

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

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

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

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

(6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

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

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

(9) "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.

(10) "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.

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

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

(13) "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.

(14) "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.

(15) "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, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(16) "Medically necessary" means services, MEDICINES, or supplies that are necessary and appropriate for the DIAGNOSIS OR treatment of a covered person's ~~emergency~~ ILLNESS, INJURY, OR medical condition ~~or for the preventive care of a covered person~~ according to accepted standards of medical practice AND THAT ARE NOT PROVIDED ONLY AS A CONVENIENCE.

(17) "Network" means the group of participating providers that provides health care services to

a managed care plan.

(18) "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.

(19) "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.

(20) "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.

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

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

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

NEW SECTION. **Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health carriers that offer managed care plans. [Sections 8 through 29] 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 12. Department -- general powers and duties -- rulemaking.** (1) The department 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 ~~[OR TO THE BOARD]~~ against a health carrier whose

managed care plan does not comply with standards for network adequacy and quality assurance adopted by the department.

(2) Quality assurance standards adopted by the department must consist of some but not all of the health plan employer data and information standards. The department shall select and adopt only standards appropriate for quality assurance in Montana.

(3) The state may contract, through a competitive bidding process, for the development of network adequacy and quality assurance standards.

NEW SECTION. **Section 13. 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)~~(4) 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)~~ (6) 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)~~ (6) 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. A health carrier shall file any subsequent material changes in its access plan with the department within 30 days of implementation of the change.

~~(6)~~(5) 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)~~(6) 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 department to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

(7) THE DEPARTMENT SHALL ENSURE TIMELY AND EXPEDITED REVIEW AND APPROVAL OF THE ACCESS PLAN AND OTHER REQUIREMENTS IN THIS SECTION.

NEW SECTION. **Section 14. Provider responsibility for care -- contracts -- prohibited collection practices.** ~~(1) A health carrier offering a managed care plan shall establish a mechanism, described in detail in the contract, 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)~~(1) 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)~~(2) 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, but not to exceed 30 days, or until the covered person's discharge from an ACUTE CARE inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an ACUTE CARE 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)~~(3) The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2) 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)~~ (1) AND (2).

~~(5)~~(4) 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 15. 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) Subsection (1) does 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 13 through 21] and the rules implementing [sections 13 through 21].

(3) [Sections 13 through 21] 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) A health carrier may use criteria established in accordance with the provisions of this section 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 selection standards.

NEW SECTION. **Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering a managed care plan shall notify, in writing, prospective participating providers of the participating providers' responsibilities concerning the health carrier's administrative policies and programs, including but not limited to payment terms, utilization reviews, 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, when the authorities are 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 60 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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.

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

(11) 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 8 through 29].

(12) A contract between a health carrier and a participating provider shall set forth all of the responsibilities and obligations of the provider either in the contract or documents referenced in the contract. A health carrier shall make its best effort to furnish copies of any reference documents, if requested by a participating provider, prior to execution of the contract.

NEW SECTION. **Section 17. 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 emergency 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 emergency 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 18. Use of intermediaries -- responsibilities of health carriers, intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions of [sections 8 through 29], 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) A health carrier may determine whether a subcontracted provider participates in the provider's

own network or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(3) 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.

(4) 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.

(5) 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.

(6) An intermediary shall allow the COMMISSIONER AND THE department 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 13 through 21] and the rules implementing [sections 13 through 21].

(7) 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 19. 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 20. 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 8 through 29] or the rules implementing [sections 8 through 29].

(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 21. 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 13 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department 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 13 through 21] and the rules implementing [sections 13 through 21] 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 13 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999.

NEW SECTION. **Section 22. Department rules.** The department shall adopt rules to implement [sections 13 through 21].

NEW SECTION. **Section 23. 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 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 department 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 24] 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 23 through 27].

(5) This section does not prevent the department from monitoring a health carrier's compliance with [sections 23 through 27].

NEW SECTION. **Section 24. 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 26];

(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 and any subsequent material changes 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 23 through 27].

NEW SECTION. **Section 25. 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 24], 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. 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;

(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 measuring, assessing and improving the outcomes of health care as identified in the health carrier's quality improvement program plan. This quality improvement program plan must be filed with the department by October 1, 2000, and must be consistent with [sections 23 through 27]. A health carrier shall file any subsequent material changes to its quality improvement program plan within 30 days of implementation of the change. The quality improvement program plan must:

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

(b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to subsection (3)(a).

NEW SECTION. **Section 26. 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.

(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 23 through 27].

(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 27] and materials that are proprietary to the managed care 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 27. 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 28. Enforcement.** (1) If the department ~~[OR THE BOARD]~~ determines that a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the department ~~[OR THE BOARD]~~ may recommend corrective action to the health carrier.

(2) ~~The~~ AT THE RECOMMENDATION OF THE DEPARTMENT ~~[OR THE BOARD]~~ THE commissioner may take an enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the department ~~[OR THE BOARD]~~;

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with [sections 8 through 29] and the rules implementing [sections 8 through 29] within a reasonable period of time;

(c) the department ~~[OR THE BOARD]~~ demonstrates to the commissioner that a health carrier does not comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]; or

(d) the commissioner determines that a health carrier has violated or is violating [sections 8 through 29] or the rules implementing [sections 8 through 29].

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]:

(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 29. Jurisdiction over contract actions.** The district courts have jurisdiction over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

~~NEW SECTION. **SECTION 30. DEFINITIONS.** AS USED IN [SECTIONS 8 THROUGH 29], THE~~

~~FOLLOWING DEFINITIONS APPLY:~~

~~(1) "BOARD" MEANS THE BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE PROVIDED FOR IN [SECTION 31].~~

~~(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) "COVERED BENEFITS" MEANS THOSE HEALTH CARE SERVICES TO WHICH A COVERED PERSON IS ENTITLED UNDER THE TERMS OF A HEALTH BENEFIT PLAN.~~

~~(5) "COVERED PERSON" MEANS A POLICYHOLDER, SUBSCRIBER, OR ENROLLEE OR OTHER INDIVIDUAL PARTICIPATING IN A HEALTH BENEFIT PLAN.~~

~~(6) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES ESTABLISHED IN 2-15-2201.~~

~~(7) "EMERGENCY MEDICAL CONDITION" MEANS A CONDITION MANIFESTING ITSELF BY SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN ANY OF THE FOLLOWING:~~

~~(A) THE COVERED PERSON'S HEALTH WOULD BE IN SERIOUS JEOPARDY;~~

~~(B) THE COVERED PERSON'S BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR~~

~~(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.~~

~~(8) "EMERGENCY SERVICES" MEANS HEALTH CARE ITEMS AND SERVICES FURNISHED OR REQUIRED TO EVALUATE AND TREAT AN EMERGENCY MEDICAL CONDITION.~~

~~(9) "FACILITY" MEANS AN INSTITUTION PROVIDING HEALTH CARE SERVICES OR A HEALTH CARE SETTING, INCLUDING BUT NOT LIMITED TO A HOSPITAL, MEDICAL ASSISTANCE FACILITY, AS DEFINED IN 50-5-101, OR OTHER LICENSED INPATIENT CENTER, AN AMBULATORY SURGICAL OR TREATMENT CENTER, A SKILLED NURSING CENTER, A RESIDENTIAL TREATMENT CENTER, A DIAGNOSTIC, LABORATORY, OR IMAGING CENTER, OR A REHABILITATION OR OTHER THERAPEUTIC HEALTH SETTING.~~

~~(10) "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.~~

~~(11) "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.~~

~~(12) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL OR A FACILITY.~~

~~(13) "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION, TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE.~~

~~(14) "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.~~

~~(15) "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.~~

~~(16) "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, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS OPERATED IN A FEE-FOR-SERVICE INDEMNITY ENVIRONMENT.~~

~~(17) "MEDICALLY NECESSARY" MEANS SERVICES OR SUPPLIES THAT ARE NECESSARY AND APPROPRIATE FOR THE TREATMENT OF A COVERED PERSON'S EMERGENCY MEDICAL CONDITION OR FOR THE PREVENTIVE CARE OF A COVERED PERSON ACCORDING TO ACCEPTED STANDARDS OF MEDICAL PRACTICE.~~

~~(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 SERVICES WITHIN A HEALTH PLAN.~~

~~NEW SECTION. **SECTION 31. 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 A SPECIALIST IN EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.~~

~~(3) THE GENERAL POWERS AND DUTIES OF THE BOARD ARE PROVIDED IN [SECTION 32].~~

~~(4) THE BOARD IS ATTACHED FOR ADMINISTRATIVE PURPOSES TO THE DEPARTMENT PURSUANT TO 2-15-121.~~

~~NEW SECTION. **SECTION 32. BOARD -- GENERAL POWERS AND DUTIES.** THE BOARD SHALL:~~

~~(1) PERIODICALLY REVIEW THE STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS PROVIDED IN [SECTIONS 8 THROUGH 29] AND THE RULES IMPLEMENTING [SECTIONS 8~~

~~THROUGH 29];~~

~~(2) RECOMMEND CORRECTIVE ACTION NECESSARY FOR THE HEALTH CARRIER TO ACHIEVE COMPLIANCE WITH STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS; AND~~

~~(3) 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.~~

NEW SECTION. **Section 30. Codification instruction.** (1) [Section 7] 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 7].

(2) [Sections 8 through ~~29~~ ~~32~~ 29] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 8 through ~~29~~ ~~32~~ 29].

NEW SECTION. **Section 31. 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 32. Applicability.** [This act] applies to a health carrier as defined in [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of this section].

NEW SECTION. **Section 33. Effective dates.** (1) Except as provided in subsections (2) and (3), [this act] is effective January 1, 1998.

(2) [Sections 22 ~~and 30 through 32, 33 THROUGH 35, AND 37~~ AND 30 THROUGH 32 and this section] are effective on passage and approval.

(3) [Sections 23 through 26] are effective October 1, 1999.

~~(4) [SECTIONS 30 THROUGH 32] AND THE LANGUAGE IN BRACKETS IN [SECTIONS 9, 12, AND 28] ARE EFFECTIVE JULY 1, 2001.~~

~~NEW SECTION. **SECTION 37. TERMINATION.** [SECTION 10] TERMINATES JUNE 30, 2001.~~

-END-

SENATE BILL NO. 365

INTRODUCED BY BENEDICT, HARGROVE, GRIMES, HARP, MERCER, AKLESTAD, AHNER, GROSFIELD, MASOLO, BAER, M. TAYLOR, MILLS, ROSE, MAHLUM, MOOD, SPRAGUE, JABS, ESTRADA, DEPRATU, FOSTER, MCNUTT, KEATING, JENKINS, CRISMORE, GLASER, HERTEL, BURNETT, THOMAS, SMITH, CRIPPEN, COLE, BOHLINGER, PECK, DENNY, OHS, GRINDE, BOOKOUT-REINICKE, BARNETT, MARSHALL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; 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; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; ~~CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;~~ AMENDING SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND PROVIDING EFFECTIVE DATES~~,~~ ~~AND~~ AND AN APPLICABILITY DATE~~, AND A TERMINATION DATE~~."

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 12, 13, and 22] require rules to be adopted by the department of public health and human services.

The rules adopted by the department must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 8 through 29] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 8 through 29].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 8 through 29], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of 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 standards that are ~~at least the equivalent of health plan employer data and information standards. Any other standards adopted must be~~ appropriate for quality assurance in Montana.

The department ~~AND SUBSEQUENTLY 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 department's rulemaking authority, the department shall specify network adequacy and quality assurance review processes.

[Section 19] 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 and quality assurance.

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

Section 1. Section 33-22-1703, MCA, is amended to read:

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

(1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(2) "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.~~ health care items or services furnished or required to evaluate and treat an emergency medical condition.

~~(2)~~(3) "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)~~(4) "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)~~ 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)~~(5) "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)~~(6) "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)~~(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

~~(7)~~(8) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider.

~~(8)~~(9) "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)~~(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

Section 2. Section 33-22-1707, MCA, is amended to read:

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

Section 3. 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. ~~THIS TERM APPLIES TO PROVIDER SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING COOPERATIVES.~~

(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~~ advanced practice registered nurse 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) "PROVIDER-SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS, HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A PHYSICIAN-HOSPITAL ORGANIZATION, A PHYSICIAN-SPONSORED NETWORK, A PHYSICIAN GROUP PRACTICE, AND A HOSPITAL-PHYSICIAN ORGANIZATION.~~

~~(12)(13)~~(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 4. Section 33-31-111, MCA, is amended to read:

"**33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to 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 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 8 through 29]."

Section 5. 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 required of the commissioner under 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 6. 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:~~

~~(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~~ is $200,000.

(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 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 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 7. 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 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care Plan Network Adequacy and Quality Assurance Act".

NEW SECTION. **Section 9. Purpose.** The purpose and intent of [sections 8 through 29] 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 implementation of 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 COORDINATED EFFORTS OF THE COMMISSIONER AND THE DEPARTMENT ~~[AND THE BOARD]~~. It is not the purpose or intent of [sections 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

NEW SECTION. **Section 10. Definitions.** As used in [sections 8 through 29], the following definitions apply:

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

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

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

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

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

(6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

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

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

(9) "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.

(10) "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.

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

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

(13) "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.

(14) "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.

(15) "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, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(16) "Medically necessary" means services, MEDICINES, or supplies that are necessary and appropriate for the DIAGNOSIS OR treatment of a covered person's ~~emergency~~ ILLNESS, INJURY, OR medical condition ~~or for the preventive care of a covered person~~ according to accepted standards of medical practice AND THAT ARE NOT PROVIDED ONLY AS A CONVENIENCE.

(17) "Network" means the group of participating providers that provides health care services to

a managed care plan.

(18) "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.

(19) "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.

(20) "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.

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

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

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

NEW SECTION. **Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health carriers that offer managed care plans. [Sections 8 through 29] 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 12. Department -- general powers and duties -- rulemaking.** (1) The department 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 ~~[OR TO THE BOARD]~~ against a health carrier whose

managed care plan does not comply with standards for network adequacy and quality assurance adopted by the department.

(2) Quality assurance standards adopted by the department must consist of some but not all of the health plan employer data and information standards. The department shall select and adopt only standards appropriate for quality assurance in Montana.

(3) The state may contract, through a competitive bidding process, for the development of network adequacy and quality assurance standards.

NEW SECTION. **Section 13. 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)~~(4) 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)~~ (6) 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)~~ (6) 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. A health carrier shall file any subsequent material changes in its access plan with the department within 30 days of implementation of the change.

~~(6)~~(5) 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)~~(6) 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 department to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

(7) THE DEPARTMENT SHALL ENSURE TIMELY AND EXPEDITED REVIEW AND APPROVAL OF THE ACCESS PLAN AND OTHER REQUIREMENTS IN THIS SECTION.

NEW SECTION. **Section 14. Provider responsibility for care -- contracts -- prohibited collection practices.** ~~(1) A health carrier offering a managed care plan shall establish a mechanism, described in detail in the contract, 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)~~(1) 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)~~(2) 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, but not to exceed 30 days, or until the covered person's discharge from an ACUTE CARE inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an ACUTE CARE 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)~~(3) The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2) 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)~~ (1) AND (2).

~~(5)~~(4) 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 15. 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) Subsection (1) does 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 13 through 21] and the rules implementing [sections 13 through 21].

(3) [Sections 13 through 21] 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) A health carrier may use criteria established in accordance with the provisions of this section 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 selection standards.

NEW SECTION. **Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering a managed care plan shall notify, in writing, prospective participating providers of the participating providers' responsibilities concerning the health carrier's administrative policies and programs, including but not limited to payment terms, utilization reviews, 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, when the authorities are 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 60 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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.

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

(11) 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 8 through 29].

(12) A contract between a health carrier and a participating provider shall set forth all of the responsibilities and obligations of the provider either in the contract or documents referenced in the contract. A health carrier shall make its best effort to furnish copies of any reference documents, if requested by a participating provider, prior to execution of the contract.

NEW SECTION. **Section 17. 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 emergency 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 emergency 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 18. Use of intermediaries -- responsibilities of health carriers, intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions of [sections 8 through 29], 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) A health carrier may determine whether a subcontracted provider participates in the provider's

own network or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(3) 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.

(4) 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.

(5) 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.

(6) An intermediary shall allow the COMMISSIONER AND THE department 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 13 through 21] and the rules implementing [sections 13 through 21].

(7) 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 19. 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 20. 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 8 through 29] or the rules implementing [sections 8 through 29].

(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 21. 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 13 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department 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 13 through 21] and the rules implementing [sections 13 through 21] 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 13 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999.

NEW SECTION. **Section 22. Department rules.** The department shall adopt rules to implement [sections 13 through 21].

NEW SECTION. **Section 23. 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 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 department 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 24] 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 23 through 27].

(5) This section does not prevent the department from monitoring a health carrier's compliance with [sections 23 through 27].

NEW SECTION. **Section 24. 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 26];

(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 and any subsequent material changes 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 23 through 27].

NEW SECTION. **Section 25. 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 24], 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. 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;

(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 measuring, assessing and improving the outcomes of health care as identified in the health carrier's quality improvement program plan. This quality improvement program plan must be filed with the department by October 1, 2000, and must be consistent with [sections 23 through 27]. A health carrier shall file any subsequent material changes to its quality improvement program plan within 30 days of implementation of the change. The quality improvement program plan must:

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

(b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to subsection (3)(a).

NEW SECTION. **Section 26. 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.

(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 23 through 27].

(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 27] and materials that are proprietary to the managed care 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 27. 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 28. Enforcement.** (1) If the department ~~[OR THE BOARD]~~ determines that a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the department ~~[OR THE BOARD]~~ may recommend corrective action to the health carrier.

(2) ~~The~~ AT THE RECOMMENDATION OF THE DEPARTMENT ~~[OR THE BOARD]~~ THE commissioner may take an enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the department ~~[OR THE BOARD]~~;

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with [sections 8 through 29] and the rules implementing [sections 8 through 29] within a reasonable period of time;

(c) the department ~~[OR THE BOARD]~~ demonstrates to the commissioner that a health carrier does not comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]; or

(d) the commissioner determines that a health carrier has violated or is violating [sections 8 through 29] or the rules implementing [sections 8 through 29].

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]:

(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 29. Jurisdiction over contract actions.** The district courts have jurisdiction over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

~~NEW SECTION. **SECTION 30. DEFINITIONS.** AS USED IN [SECTIONS 8 THROUGH 29], THE~~

~~FOLLOWING DEFINITIONS APPLY:~~

~~(1) "BOARD" MEANS THE BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE PROVIDED FOR IN [SECTION 31].~~

~~(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) "COVERED BENEFITS" MEANS THOSE HEALTH CARE SERVICES TO WHICH A COVERED PERSON IS ENTITLED UNDER THE TERMS OF A HEALTH BENEFIT PLAN.~~

~~(5) "COVERED PERSON" MEANS A POLICYHOLDER, SUBSCRIBER, OR ENROLLEE OR OTHER INDIVIDUAL PARTICIPATING IN A HEALTH BENEFIT PLAN.~~

~~(6) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES ESTABLISHED IN 2-15-2201.~~

~~(7) "EMERGENCY MEDICAL CONDITION" MEANS A CONDITION MANIFESTING ITSELF BY SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN ANY OF THE FOLLOWING:~~

~~(A) THE COVERED PERSON'S HEALTH WOULD BE IN SERIOUS JEOPARDY;~~

~~(B) THE COVERED PERSON'S BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR~~

~~(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.~~

~~(8) "EMERGENCY SERVICES" MEANS HEALTH CARE ITEMS AND SERVICES FURNISHED OR REQUIRED TO EVALUATE AND TREAT AN EMERGENCY MEDICAL CONDITION.~~

~~(9) "FACILITY" MEANS AN INSTITUTION PROVIDING HEALTH CARE SERVICES OR A HEALTH CARE SETTING, INCLUDING BUT NOT LIMITED TO A HOSPITAL, MEDICAL ASSISTANCE FACILITY, AS DEFINED IN 50-5-101, OR OTHER LICENSED INPATIENT CENTER, AN AMBULATORY SURGICAL OR TREATMENT CENTER, A SKILLED NURSING CENTER, A RESIDENTIAL TREATMENT CENTER, A DIAGNOSTIC, LABORATORY, OR IMAGING CENTER, OR A REHABILITATION OR OTHER THERAPEUTIC HEALTH SETTING.~~

~~(10) "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.~~

~~(11) "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.~~

~~(12) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL OR A FACILITY.~~

~~(13) "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION, TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE.~~

~~(14) "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.~~

~~(15) "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.~~

~~(16) "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, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS OPERATED IN A FEE-FOR-SERVICE INDEMNITY ENVIRONMENT.~~

~~(17) "MEDICALLY NECESSARY" MEANS SERVICES OR SUPPLIES THAT ARE NECESSARY AND APPROPRIATE FOR THE TREATMENT OF A COVERED PERSON'S EMERGENCY MEDICAL CONDITION OR FOR THE PREVENTIVE CARE OF A COVERED PERSON ACCORDING TO ACCEPTED STANDARDS OF MEDICAL PRACTICE.~~

~~(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 SERVICES WITHIN A HEALTH PLAN.~~

~~NEW SECTION. **SECTION 31. 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 A SPECIALIST IN EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.~~

~~(3) THE GENERAL POWERS AND DUTIES OF THE BOARD ARE PROVIDED IN [SECTION 32].~~

~~(4) THE BOARD IS ATTACHED FOR ADMINISTRATIVE PURPOSES TO THE DEPARTMENT PURSUANT TO 2-15-121.~~

~~NEW SECTION. **SECTION 32. BOARD -- GENERAL POWERS AND DUTIES.** THE BOARD SHALL:~~

~~(1) PERIODICALLY REVIEW THE STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS PROVIDED IN [SECTIONS 8 THROUGH 29] AND THE RULES IMPLEMENTING [SECTIONS 8~~

~~THROUGH 29];~~

~~(2) RECOMMEND CORRECTIVE ACTION NECESSARY FOR THE HEALTH CARRIER TO ACHIEVE COMPLIANCE WITH STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS; AND~~

~~(3) 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.~~

NEW SECTION. **Section 30. Codification instruction.** (1) [Section 7] 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 7].

(2) [Sections 8 through ~~29~~ ~~32~~ 29] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 8 through ~~29~~ ~~32~~ 29].

NEW SECTION. **Section 31. 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 32. Applicability.** [This act] applies to a health carrier as defined in [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of this section].

NEW SECTION. **Section 33. Effective dates.** (1) Except as provided in subsections (2) and (3), [this act] is effective January 1, 1998.

(2) [Sections 22 ~~and 30 through 32, 33 THROUGH 35, AND 37~~ AND 30 THROUGH 32 and this section] are effective on passage and approval.

(3) [Sections 23 through 26] are effective October 1, 1999.

~~(4) [SECTIONS 30 THROUGH 32] AND THE LANGUAGE IN BRACKETS IN [SECTIONS 9, 12, AND 28] ARE EFFECTIVE JULY 1, 2001.~~

~~NEW SECTION. **SECTION 37. TERMINATION.** [SECTION 10] TERMINATES JUNE 30, 2001.~~

-END-

OFFICE OF THE GOVERNOR

STATE OF MONTANA

MARC RACICOT
GOVERNOR

STATE CAPITOL
HELENA, MONTANA 59620-0801

April 21, 1997

The Honorable Gary Aklestad
President of the Senate
State Capitol
Helena MT 59620

The Honorable John Mercer
Speaker of the House
State Capitol
Helena MT 59620

Dear President Aklestad and Speaker Mercer:

In accordance with the power vested in me as Governor by the Constitution and laws of the State of Montana, I hereby return with amendments Senate Bill 365, **"AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; 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; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS 33-22-1703, 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"** for the following reasons.

Senate Bill 365 establishes adequate health care networks and quality of managed care. It is an important and visionary bill that will benefit both consumers and managed health care providers in Montana. Applications for health maintenance organizations are pending, and the bill needs to be passed this session.

However, Senate Bill 365 will have a fiscal impact on both the Department of Public

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SB 365

Health and Human Services, as well as the State Auditor's Office. These costs were not funded in House Bill 2, and thus it will be necessary to delay the effective dates of several of the sections of Senate Bill 365.

Senator Benedict, the bill's sponsor, has been informed of the need for these amendments.

Sincerely,

MARC RACICOT
Governor

GOVERNOR'S AMENDMENTS TO
Senate Bill No. 365
(Reference Copy)
April 21, 1997

Page 15, line 3.
Strike: "1998"
Insert: "1999"
Following: " October 1,"

Page 15, line 4.
Strike: "1998"
Insert: "1999"
Following: "October 1,"

Page 15, line 6.
Strike: "1998"
Insert: "1999"
Following: "October 1,"

Page 21, line 24.
Strike: "1998"
Insert: "1999"
Following: "October 1,"

Page 22, line 13.
Strike: "1997"
Insert: "1999"
Following: "October 1,"

Page 22, line 14.
Strike: "April"
Insert: "October"
Following: "by"

Page 22, line 15.
Strike: "April"
Insert: "October"

GOVERNOR'S AMENDMENTS TO
Senate Bill No. 365
(Reference Copy)
April 21, 1997

Page 22, line 18.
Strike: "April 1, 1998"
Insert: "October 1, 1999"
Following: "after"

Page 22, line 22.
Strike: "April"
Insert: "October"
Following: "by"

Page 22, line 24.
Strike: "shall"
Insert: "may"
Following: "department"

Page 30, Line 24.
Insert: "12,"
Following: "Sections"

Page 30, line 26.
Insert: "13, 15, 18 through 21,"
Following: "Sections"
Strike: "26"
Insert: "29"

SENATE BILL NO. 365

INTRODUCED BY BENEDICT, HARGROVE, GRIMES, HARP, MERCER, AKLESTAD, AHNER, GROSFIELD, MASOLO, BAER, M. TAYLOR, MILLS, ROSE, MAHLUM, MOOD, SPRAGUE, JABS, ESTRADA, DEPRATU, FOSTER, MCNUTT, KEATING, JENKINS, CRISMORE, GLASER, HERTEL, BURNETT, THOMAS, SMITH, CRIPPEN, COLE, BOHLINGER, PECK, DENNY, OHS, GRINDE, BOOKOUT-REINICKE, BARNETT, MARSHALL

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE CARRIERS WHO OFFER MANAGED CARE PLANS; 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; PROVIDING DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE ORGANIZATIONS; ~~CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;~~ AMENDING SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND PROVIDING EFFECTIVE DATES~~, AND~~ AND AN APPLICABILITY DATE~~, AND A TERMINATION DATE~~."

STATEMENT OF INTENT

A statement of intent is required for this bill because [sections 12, 13, and 22] require rules to be adopted by the department of public health and human services.

The rules adopted by the department must establish state network adequacy and quality assurance standards for managed care plans that amplify [sections 8 through 29] and must provide greater detail regarding specific means by which a health carrier meets the requirements of [sections 8 through 29].

A managed care plan accredited by a nationally recognized organization is not required to meet some of the provisions of [sections 8 through 29], but the legislature acknowledges that small managed care plans may not be capable of meeting all of the accreditation requirements of national accrediting organizations.

REFERENCE BILL: INCLUDES GOVERNOR'S AMENDMENTS DATED 4-21-97

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 standards that are ~~at least the equivalent of health plan employer data and information standards. Any other standards adopted must be~~ appropriate for quality assurance in Montana.

The department ~~AND SUBSEQUENTLY 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 department's rulemaking authority, the department shall specify network adequacy and quality assurance review processes.

[Section 19] 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 and quality assurance.

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

Section 1. Section 33-22-1703, MCA, is amended to read:

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

(1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(2) "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.~~ health care items or services furnished or required to evaluate and treat an emergency medical condition.

~~(2)~~(3) "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)~~(4) "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)~~ 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)~~(5) "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)~~(6) "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)~~(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

~~(7)~~(8) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider.

~~(8)~~(9) "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)~~(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

Section 2. Section 33-22-1707, MCA, is amended to read:

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

Section 3. 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. ~~THIS TERM APPLIES TO PROVIDER-SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING COOPERATIVES.~~

(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~~ advanced practice registered nurse 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) "PROVIDER-SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS, HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A PHYSICIAN-HOSPITAL ORGANIZATION, A PHYSICIAN-SPONSORED NETWORK, A PHYSICIAN GROUP PRACTICE, AND A HOSPITAL-PHYSICIAN ORGANIZATION.~~

~~(12)(13)~~(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 4. Section 33-31-111, MCA, is amended to read:

"**33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to 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 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 8 through 29]."

Section 5. 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 required of the commissioner under 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 6. 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:~~

~~(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~~ is $200,000.

(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 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 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 7. 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 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care Plan Network Adequacy and Quality Assurance Act".

NEW SECTION. **Section 9. Purpose.** The purpose and intent of [sections 8 through 29] 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 implementation of 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 COORDINATED EFFORTS OF THE COMMISSIONER AND THE DEPARTMENT ~~[AND THE BOARD]~~. It is not the purpose or intent of [sections 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

NEW SECTION. **Section 10. Definitions.** As used in [sections 8 through 29], the following definitions apply:

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

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

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

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

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

(6) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

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

(8) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, medical assistance facility, as defined in 50-5-101, or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or a rehabilitation or other therapeutic health setting.

(9) "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.

(10) "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.

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

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

(13) "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.

(14) "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.

(15) "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, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(16) "Medically necessary" means services, MEDICINES, or supplies that are necessary and appropriate for the DIAGNOSIS OR treatment of a covered person's ~~emergency~~ ILLNESS, INJURY, OR medical condition ~~or for the preventive care of a covered person~~ according to accepted standards of medical practice AND THAT ARE NOT PROVIDED ONLY AS A CONVENIENCE.

(17) "Network" means the group of participating providers that provides health care services to

a managed care plan.

(18) "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.

(19) "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.

(20) "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.

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

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

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

NEW SECTION. **Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health carriers that offer managed care plans. [Sections 8 through 29] 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 12. Department -- general powers and duties -- rulemaking.** (1) The department 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 ~~[OR TO THE BOARD]~~ against a health carrier whose

managed care plan does not comply with standards for network adequacy and quality assurance adopted by the department.

(2) Quality assurance standards adopted by the department must consist of some but not all of the health plan employer data and information standards. The department shall select and adopt only standards appropriate for quality assurance in Montana.

(3) The state may contract, through a competitive bidding process, for the development of network adequacy and quality assurance standards.

NEW SECTION. **Section 13. 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)~~(4) A health carrier offering a managed care plan in this state on October 1, ~~1998~~ 1999, shall file with the department on October 1, ~~1998~~ 1999, an access plan complying with subsection ~~(7)~~ (6) 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~~ 1999, shall file with the department an access plan meeting the requirements of subsection ~~(7)~~ (6) 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. A health carrier shall file any subsequent material changes in its access plan with the department within 30 days of implementation of the change.

~~(6)~~(5) 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)~~(6) 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 department to determine compliance with [sections 13 through 21] and the rules implementing [sections 13 through 21].

(7) THE DEPARTMENT SHALL ENSURE TIMELY AND EXPEDITED REVIEW AND APPROVAL OF THE ACCESS PLAN AND OTHER REQUIREMENTS IN THIS SECTION.

NEW SECTION. **Section 14. Provider responsibility for care -- contracts -- prohibited collection practices.** ~~(1) A health carrier offering a managed care plan shall establish a mechanism, described in detail in the contract, 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)~~(1) 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)~~(2) 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, but not to exceed 30 days, or until the covered person's discharge from an ACUTE CARE inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an ACUTE CARE 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)~~(3) The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2) 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)~~ (1) AND (2).

~~(5)~~(4) 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 15. 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) Subsection (1) does 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 13 through 21] and the rules implementing [sections 13 through 21].

(3) [Sections 13 through 21] 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) A health carrier may use criteria established in accordance with the provisions of this section 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 selection standards.

NEW SECTION. **Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering a managed care plan shall notify, in writing, prospective participating providers of the participating providers' responsibilities concerning the health carrier's administrative policies and programs, including but not limited to payment terms, utilization reviews, 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, when the authorities are 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 60 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.

(6) 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.

(7) 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.

(8) 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.

(9) 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.

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

(11) 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 8 through 29].

(12) A contract between a health carrier and a participating provider shall set forth all of the responsibilities and obligations of the provider either in the contract or documents referenced in the contract. A health carrier shall make its best effort to furnish copies of any reference documents, if

requested by a participating provider, prior to execution of the contract.

NEW SECTION. **Section 17. 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 emergency 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 emergency 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 18. Use of intermediaries -- responsibilities of health carriers, intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions of [sections 8 through 29], 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) A health carrier may determine whether a subcontracted provider participates in the provider's own network or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(3) 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.

(4) 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.

(5) 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.

(6) An intermediary shall allow the COMMISSIONER AND THE department 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 13 through 21] and the rules implementing [sections 13 through 21].

(7) 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 19. Contract filing requirements -- material changes -- state access to contracts.** (1) On October 1, ~~1998~~ 1999, 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 20. 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 8 through 29] or the rules implementing [sections 8 through 29].

(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 21. Contract compliance dates.** (1) A contract between a health carrier and a participating provider or intermediary in effect on October 1, ~~1997~~ 1999, must comply with [sections 13 through 21] and the rules implementing [sections 13 through 21] by ~~April~~ OCTOBER 1, 1999. The department may extend the ~~April~~ OCTOBER 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~~ OCTOBER 1, 1999, must comply with [sections 13 through 21] and the rules implementing [sections 13 through 21] 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 13 through 21] and the rules implementing [sections 13 through 21] by ~~April~~ OCTOBER 1, 1999.

NEW SECTION. **Section 22. Department rules.** The department ~~shall~~ MAY adopt rules to implement [sections 13 through 21].

NEW SECTION. **Section 23. 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 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 department 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 24] 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 23 through 27].

(5) This section does not prevent the department from monitoring a health carrier's compliance with [sections 23 through 27].

NEW SECTION. **Section 24. 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 26];

(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 and any subsequent material changes 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 23 through 27].

NEW SECTION. **Section 25. 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 24], 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. 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;

(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 measuring, assessing and improving the outcomes of health care as identified in the health carrier's quality improvement program plan. This quality improvement program plan must be filed with the department by October 1, 2000, and must be consistent with [sections 23 through 27]. A health carrier shall file any subsequent material changes to its quality improvement program plan within 30 days of implementation of the change. The quality improvement program plan must:

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

(b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to subsection (3)(a).

NEW SECTION. **Section 26. 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.

(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 23 through 27].

(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 27] and materials that are proprietary to the managed care 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 27. 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 28. Enforcement.** (1) If the department ~~{OR THE BOARD}~~ determines that a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the department ~~{OR THE BOARD}~~ may recommend corrective action to the health carrier.

(2) ~~The~~ AT THE RECOMMENDATION OF THE DEPARTMENT ~~{OR THE BOARD}~~ THE commissioner may take an enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the department ~~{OR THE BOARD}~~;

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with [sections 8 through 29] and the rules implementing [sections 8 through 29] within a reasonable period of time;

(c) the department ~~{OR THE BOARD}~~ demonstrates to the commissioner that a health carrier does not comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]; or

(d) the commissioner determines that a health carrier has violated or is violating [sections 8 through 29] or the rules implementing [sections 8 through 29].

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with [sections 8 through 29] or the rules implementing [sections 8 through 29]:

(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 29. Jurisdiction over contract actions.** The district courts have jurisdiction over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

~~NEW SECTION. **SECTION 30. DEFINITIONS.** AS USED IN [SECTIONS 8 THROUGH 29], THE FOLLOWING DEFINITIONS APPLY:~~

~~(1) "BOARD" MEANS THE BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE PROVIDED FOR IN [SECTION 31].~~

~~(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) "COVERED BENEFITS" MEANS THOSE HEALTH CARE SERVICES TO WHICH A COVERED PERSON IS ENTITLED UNDER THE TERMS OF A HEALTH BENEFIT PLAN.~~

~~(5) "COVERED PERSON" MEANS A POLICYHOLDER, SUBSCRIBER, OR ENROLLEE OR OTHER INDIVIDUAL PARTICIPATING IN A HEALTH BENEFIT PLAN.~~

~~(6) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES ESTABLISHED IN 2-15-2201.~~

~~(7) "EMERGENCY MEDICAL CONDITION" MEANS A CONDITION MANIFESTING ITSELF BY SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN ANY OF THE FOLLOWING:~~

~~(A) THE COVERED PERSON'S HEALTH WOULD BE IN SERIOUS JEOPARDY;~~

~~(B) THE COVERED PERSON'S BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR~~

~~(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.~~

~~(8) "EMERGENCY SERVICES" MEANS HEALTH CARE ITEMS AND SERVICES FURNISHED OR REQUIRED TO EVALUATE AND TREAT AN EMERGENCY MEDICAL CONDITION.~~

~~(9) "FACILITY" MEANS AN INSTITUTION PROVIDING HEALTH CARE SERVICES OR A HEALTH CARE SETTING, INCLUDING BUT NOT LIMITED TO A HOSPITAL, MEDICAL ASSISTANCE FACILITY, AS DEFINED IN 50-5-101, OR OTHER LICENSED INPATIENT CENTER, AN AMBULATORY SURGICAL OR TREATMENT CENTER, A SKILLED NURSING CENTER, A RESIDENTIAL TREATMENT CENTER, A DIAGNOSTIC, LABORATORY, OR IMAGING CENTER, OR A REHABILITATION OR OTHER THERAPEUTIC HEALTH SETTING.~~

~~(10) "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.~~

~~(11) "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.~~

~~(12) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL OR A FACILITY.~~

~~(13) "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION, TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE.~~

~~(14) "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.~~

~~(15) "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.~~

~~(16) "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, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS OPERATED IN A FEE-FOR-SERVICE INDEMNITY ENVIRONMENT.~~

~~(17) "MEDICALLY NECESSARY" MEANS SERVICES OR SUPPLIES THAT ARE NECESSARY AND APPROPRIATE FOR THE TREATMENT OF A COVERED PERSON'S EMERGENCY MEDICAL CONDITION OR FOR THE PREVENTIVE CARE OF A COVERED PERSON ACCORDING TO ACCEPTED STANDARDS OF MEDICAL PRACTICE.~~

~~(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 SERVICES WITHIN A HEALTH PLAN.~~

~~NEW SECTION. **SECTION 31. 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 A SPECIALIST IN EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.~~

~~(3) THE GENERAL POWERS AND DUTIES OF THE BOARD ARE PROVIDED IN [SECTION 32].~~

~~(4) THE BOARD IS ATTACHED FOR ADMINISTRATIVE PURPOSES TO THE DEPARTMENT PURSUANT TO 2-15-121.~~

~~NEW SECTION. **SECTION 32. BOARD -- GENERAL POWERS AND DUTIES.** THE BOARD SHALL:~~

~~(1) PERIODICALLY REVIEW THE STATE NETWORK ADEQUACY AND QUALITY ASSURANCE~~

~~STANDARDS PROVIDED IN [SECTIONS 8 THROUGH 29] AND THE RULES IMPLEMENTING [SECTIONS 8 THROUGH 29];~~

~~(2) RECOMMEND CORRECTIVE ACTION NECESSARY FOR THE HEALTH CARRIER TO ACHIEVE COMPLIANCE WITH STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS; AND~~

~~(3) 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.~~

NEW SECTION. **Section 30. Codification instruction.** (1) [Section 7] 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 7].

(2) [Sections 8 through ~~29~~ 32 29] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 8 through ~~29~~ 32 29].

NEW SECTION. **Section 31. 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 32. Applicability.** [This act] applies to a health carrier as defined in [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of this section].

NEW SECTION. **Section 33. Effective dates.** (1) Except as provided in subsections (2) and (3), [this act] is effective January 1, 1998.

(2) [Sections 12, 22, ~~and 30 through 32, 33 THROUGH 35, AND 37~~ AND 30 THROUGH 32 and this section] are effective on passage and approval.

(3) [Sections 13, 15, 18 THROUGH 21, AND 23 through ~~26~~ 29] are effective October 1, 1999.

~~(4) [SECTIONS 30 THROUGH 32] AND THE LANGUAGE IN BRACKETS IN [SECTIONS 9, 12, AND 28] ARE EFFECTIVE JULY 1, 2001.~~

~~NEW SECTION. **SECTION 37. TERMINATION.** [SECTION 10] TERMINATES JUNE 30, 2001.~~

-END-