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Sen. BILL NO. 365 *Grosfreed*
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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

1 adequacy and quality assurance review processes.

2 [Section 19] designates the department of public health and human services as the place for
3 insurance carriers to file documents related to managed care provider network adequacy and quality
4 assurance. The department shall adopt rules establishing procedures for filing these documents and shall
5 adopt rules specifying processes for amending or withdrawing documents already filed that relate to
6 network adequacy and quality assurance.

7

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

9

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

11 **"33-22-1703. Definitions.** As used in this part, the following definitions apply:

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

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

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

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

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

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

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

24 ~~(c) a bodily organ or part would be seriously damaged.~~ health care items or services furnished or
25 required to evaluate and treat an emergency medical condition.

26 ~~(2)(3)~~ (3) "Health benefit plan" means the health insurance policy or subscriber arrangement between
27 the insured or subscriber and the health care insurer that defines the covered services and benefit levels
28 available.

29 ~~(3)(4)~~ (4) "Health care insurer" means:

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

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

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

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

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

6 ~~(4)~~(5) "Health care services" means health care services or products rendered or sold by a provider
7 within the scope of the provider's license or legal authorization or services provided under Title 33, chapter
8 22, part 7.

9 ~~(5)~~(6) "Insured" means an individual entitled to reimbursement for expenses of health care services
10 under a policy or subscriber contract issued or administered by an insurer.

11 ~~(6)~~(7) "Preferred provider" means a provider or group of providers who have contracted to provide
12 specified health care services.

13 ~~(7)~~(8) "Preferred provider agreement" means a contract between or on behalf of a health care
14 insurer and a preferred provider.

15 ~~(8)~~(9) "Provider" means an individual or entity licensed or legally authorized to provide health care
16 services or services covered within Title 33, chapter 22, part 7.

17 ~~(9)~~(10) "Subscriber" means a certificate holder or other person on whose behalf the health care
18 insurer is providing or paying for health care coverage."

19
20 **Section 2.** Section 33-22-1707, MCA, is amended to read:

21 "**33-22-1707. Rules.** The commissioner ~~shall promulgate~~ may adopt rules necessary to implement
22 the provisions of this part."

23
24 **Section 3.** Section 33-31-102, MCA, is amended to read:

25 "**33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the
26 following definitions apply: ,

27 (1) "Basic health care services" means:

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

29 (b) inpatient hospital and provider care;

30 (c) outpatient medical services;

- 1 (d) medical treatment and referral services;
- 2 (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant
3 to 33-31-301(3)(e);
- 4 (f) care and treatment of mental illness, alcoholism, and drug addiction;
- 5 (g) diagnostic laboratory and diagnostic and therapeutic radiologic services;
- 6 (h) preventive health services, including:
- 7 (i) immunizations;
- 8 (ii) well-child care from birth;
- 9 (iii) periodic health evaluations for adults;
- 10 (iv) voluntary family planning services;
- 11 (v) infertility services; and
- 12 (vi) children's eye and ear examinations conducted to determine the need for vision and hearing
13 correction;
- 14 (i) minimum mammography examination, as defined in 33-22-132; and
- 15 (j) treatment for phenylketonuria. "Treatment" means licensed professional medical services under
16 the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels
17 of phenylalanine and adequate nutritional status.
- 18 (2) "Commissioner" means the commissioner of insurance of the state of Montana.
- 19 (3) "Enrollee" means a person:
- 20 (a) who enrolls in or contracts with a health maintenance organization;
- 21 (b) on whose behalf a contract is made with a health maintenance organization to receive health
22 care services; or
- 23 (c) on whose behalf the health maintenance organization contracts to receive health care services.
- 24 (4) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee
25 setting forth the coverage to which the enrollee is entitled.
- 26 (5) "Health care services" means:
- 27 (a) the services included in furnishing medical or dental care to a person;
- 28 (b) the services included in hospitalizing a person;
- 29 (c) the services incident to furnishing medical or dental care or hospitalization; or
- 30 (d) the services included in furnishing to a person other services for the purpose of preventing,

1 alleviating, curing, or healing illness, injury, or physical disability.

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

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

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

11 (9) "Person" means:

12 (a) an individual;

13 (b) a group of individuals;

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

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

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

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

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

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

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

29

30 **Section 4.** Section 33-31-111, MCA, is amended to read:

1 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise
 2 provided in this chapter, the insurance or health service corporation laws do not apply to any health
 3 maintenance organization authorized to transact business under this chapter. This provision does not apply
 4 to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
 5 corporation laws of this state except with respect to its health maintenance organization activities
 6 authorized and regulated pursuant to this chapter.

7 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority
 8 or its representatives ~~may not be construed as~~ is not a violation of any law relating to solicitation or
 9 advertising by health professionals.

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

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

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

17 (6) This section does not exempt a health maintenance organization from network adequacy and
 18 quality assurance requirements provided under [sections 8 through 29]."

19
 20 **Section 5.** Section 33-31-211, MCA, is amended to read:

21 **"33-31-211. Annual ~~statement~~ statements -- revocation for failure to file -- penalty for false**
 22 **swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized
 23 health maintenance organization shall annually on or before March 1 file with the commissioner a full and
 24 true statement of its financial condition, transactions, and affairs as of the preceding December 31. The
 25 statement must be in the general form and content required by the commissioner. The statement must be
 26 verified by the oath of at least two principal officers of the health maintenance organization. The
 27 commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance
 28 organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file
 29 on or before June 1 an audited financial statement.

30 (2) At the time of filing ~~its~~ the annual statement required by March 1, the health maintenance

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

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

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

13

14 **Section 6.** Section 33-31-216, MCA, is amended to read:

15 **"33-31-216. Protection against insolvency.** (1) Except as provided in subsections (4) through (7),
 16 each authorized health maintenance organization shall deposit with the commissioner cash, securities, or
 17 any combination of cash or securities acceptable to the commissioner in the amount set forth in this
 18 section.

19 (2) The amount of the deposit for a health maintenance organization during the first year of its
 20 operation ~~must be the greater of:~~

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

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

23 ~~(c) \$100,000 is \$200,000.~~

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

28 (4) Unless not applicable, a health maintenance organization that is in operation on October 1,
 29 1987, shall make a deposit equal to the greater of:

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

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

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

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

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

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

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

1 least equal to the capital and surplus requirements for a disability insurer.

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

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

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

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

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

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

23
24 **NEW SECTION. Section 7. Premium increase restriction -- exception.** (1) A health maintenance
25 organization may not increase a premium for an individual's or an individual's group health care services
26 agreement more frequently than once during a 12-month period unless failure to increase the premium more
27 frequently than once during the 12-month period would:

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

29 (b) cause the financial impairment of the health maintenance organization to the extent that further
30 transaction of insurance by the health maintenance organization would injure or be hazardous to its

1 enrollees or to the public.

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

4

5 **NEW SECTION. Section 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care
6 Plan Network Adequacy and Quality Assurance Act".

7

8 **NEW SECTION. Section 9. Purpose.** The purpose and intent of [sections 8 through 29] are to:

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

14 (2) provide for the implementation of state network adequacy and quality assurance standards in
15 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for
16 detecting and reporting violations of those standards to the commissioner;

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

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

22 (5) provide a streamlined and simplified process by which managed care network adequacy and
23 quality assurance programs may be monitored for compliance. It is not the purpose or intent of [sections
24 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care
25 plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance
26 programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

27

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

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

1 participating providers under the terms of the managed care plan.

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

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

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

7 (5) "Department" means the department of public health and human services established in
8 2-15-2201.

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

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

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

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

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

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

21 (9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered,
22 or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health
23 care services.

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

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

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

30 (13) "Health carrier" means an entity subject to the insurance laws and rules of this state that

1 contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or
2 reimburse any of the costs of health care services, including a disability insurer, health maintenance
3 organization, or health service corporation or another entity providing a health benefit plan.

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

6 (15) "Managed care plan" means a health benefit plan that either requires or creates incentives,
7 including financial incentives, for a covered person to use health care providers managed, owned, under
8 contract with, or employed by a health carrier, but not preferred provider organizations or other provider
9 networks operated in a fee-for-service indemnity environment.

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

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

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

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

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

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

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

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

1 **NEW SECTION. Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health
2 carriers that offer managed care plans. [Sections 8 through 29] do not exempt a health carrier from the
3 applicable requirements of federal law when providing a managed care plan to medicare recipients or from
4 the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to
5 medicaid recipients.

6
7 **NEW SECTION. Section 12. Department -- general powers and duties -- rulemaking.** (1) The
8 department shall:

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

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

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

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

19
20 **NEW SECTION. Section 13. Network adequacy -- standards -- access plan required.** (1) A health
21 carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and
22 types of providers to ensure that all services to covered persons are accessible without unreasonable delay.
23 Sufficiency in number and type of provider is determined in accordance with the requirements of this
24 section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health
25 carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria
26 may include but are not limited to:

- 27 (a) a ratio of specialty care providers to covered persons;
28 (b) a ratio of primary care providers to covered persons;
29 (c) geographic accessibility;
30 (d) waiting times for appointments with participating providers;

1 (e) hours of operation; or

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

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

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

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

14 (5) A health carrier offering a managed care plan in this state on October 1, 1998, shall file with
15 the department on October 1, 1998, an access plan complying with subsection (7) and the rules of the
16 department. A health carrier offering a managed care plan in this state for the first time after October 1,
17 1998, shall file with the department an access plan meeting the requirements of subsection (7) and the
18 rules of the department before offering the managed care plan. A plan must be filed with the department
19 in a manner and form complying with the rules of the department. A health carrier shall file any subsequent
20 material changes in its access plan with the department within 30 days of implementation of the change.

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

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

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

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

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

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

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

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

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

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

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

20 (j) any other information required by the department to determine compliance with [sections 13
21 through 21] and the rules implementing [sections 13 through 21].

22
23 **NEW SECTION. Section 14. Provider responsibility for care -- contracts -- prohibited collection**
24 **practices.** (1) A health carrier offering a managed care plan shall establish a mechanism, described in detail
25 in the contract, by which a participating provider will be notified on an ongoing basis of the covered health
26 care services for which the participating provider is responsible, including any limitations or conditions on
27 those health care services.

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

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

15 (3) A contract between a health carrier and a participating provider must state that if a health
16 carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered
17 persons will continue through the end of the period for which a premium has been paid to the health carrier
18 on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from
19 an inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an inpatient
20 facility on the date of insolvency or other cessation of operations must be continued by a provider until the
21 confinement in an inpatient facility is no longer medically necessary.

22 (4) The contract provisions that satisfy the requirements of subsections (2) and (3) must be
23 construed in favor of the covered person, survive the termination of the contract regardless of the reason
24 for termination, including the insolvency of the health carrier, and supersede an oral or written contrary
25 agreement between a participating provider and a covered person or the representative of a covered person
26 if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits
27 provisions required by subsections (2) and (3).

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

30

1 **NEW SECTION.** **Section 15. Selection of providers -- professional credentials standards.** (1) A
2 health carrier shall adopt standards for selecting participating providers who are primary care professionals
3 and for each health care professional specialty within the health carrier's network. The health carrier shall
4 use the standards to select health care professionals, the health carrier's intermediaries, and any provider
5 network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow
6 the health carrier to:

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

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

12 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails
13 to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 13
14 through 21] and the rules implementing [sections 13 through 21].

15 (3) [Sections 13 through 21] do not require a health carrier, its intermediary, or a provider network
16 with which the health carrier or its intermediary contract to employ specific providers or types of providers
17 who may meet their selection criteria or to contract with or retain more providers or types of providers than
18 are necessary to maintain an adequate network.

19 (4) A health carrier may use criteria established in accordance with the provisions of this section
20 to select health care professionals allowed to participate in the health carrier's managed care plan. A health
21 carrier shall make its selection standards for participating providers available for review by the department
22 and by each health care professional who is subject to the selection standards.

23
24 **NEW SECTION.** **Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering
25 a managed care plan shall notify, in writing, prospective participating providers of the participating
26 providers' responsibilities concerning the health carrier's administrative policies and programs, including but
27 not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance
28 procedures, data reporting requirements, confidentiality requirements, and applicable federal or state
29 requirements.

30 (2) A health carrier may not offer an inducement under a managed care plan to a participating

1 provider to provide less than medically necessary services to a covered person.

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

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

9 (5) A health carrier and participating provider shall provide at least 60 days' written notice to each
10 other before terminating the contract between them without cause. The health carrier shall make a good
11 faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a
12 notice of termination from or to a participating provider, to all covered persons who are patients seen on
13 a regular basis by the participating provider whose contract is terminating, irrespective of whether the
14 termination is for cause or without cause. If a contract termination involves a primary care professional,
15 all covered persons who are patients of that primary care professional must be notified.

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

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

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

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

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

3 (11) A contract between a health carrier and a participating provider may not contain definitions
4 or other provisions that conflict with the definitions or provisions contained in the managed care plan or
5 [sections 8 through 29].

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

10
11 **NEW SECTION. Section 17. Emergency services.** (1) A health carrier offering a managed care plan
12 shall provide or pay for emergency services screening and emergency services and may not require prior
13 authorization for either of those services. If an emergency services screening determines that emergency
14 services or emergency services of a particular type are unnecessary for a covered person, emergency
15 services or emergency services of the type determined unnecessary by the screening need not be covered
16 by the health carrier unless otherwise covered under the health benefit plan. However, if screening
17 determines that emergency services or emergency services of a particular type are necessary, those
18 services must be covered by the health carrier. A health carrier shall cover emergency services if the health
19 carrier, acting through a participating provider or other authorized representative, has authorized the
20 provision of emergency services.

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

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

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

1 deductibles.

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

5

6 **NEW SECTION. Section 18. Use of intermediaries -- responsibilities of health carriers,**
7 **intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions
8 of [sections 8 through 29], and contracting with an intermediary for all or some of the services for which
9 a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

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

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

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

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

25 (6) An intermediary shall allow the department access to the intermediary's books, records, claim
26 information, billing information, and other documentation of services provided to covered persons that are
27 required by any of those entities to determine compliance with [sections 13 through 21] and the rules
28 implementing [sections 13 through 21].

29 (7) A health carrier may, in the event of the intermediary's insolvency, require the assignment to
30 the health carrier of the provisions of a participating provider's contract addressing the participating

1 provider's obligation to furnish covered benefits.

2

3 **NEW SECTION. Section 19. Contract filing requirements -- material changes -- state access to**
4 **contracts.** (1) On October 1, 1998, a health carrier offering a managed care plan shall file with the
5 department sample contract forms proposed for use with its participating providers and intermediaries.

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

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

13

14 **NEW SECTION. Section 20. General contracting requirements.** (1) The execution of a contract
15 for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty
16 to provide health care services to a person with whom the health carrier has contracted and does not
17 relieve the health carrier of its responsibility for compliance with [sections 8 through 29] or the rules
18 implementing [sections 8 through 29].

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

21

22 **NEW SECTION. Section 21. Contract compliance dates.** (1) A contract between a health carrier
23 and a participating provider or intermediary in effect on October 1, 1997, must comply with [sections 13
24 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department may
25 extend the April 1 date for an additional period of up to 6 months if the health carrier demonstrates good
26 cause for an extension.

27 (2) A contract between a health carrier and a participating provider or intermediary issued or put
28 into effect on or after April 1, 1998, must comply with [sections 13 through 21] and the rules implementing
29 [sections 13 through 21] on the day that it is issued or put into effect.

30 (3) A contract between a health carrier and a participating provider or intermediary not described

1 in subsection (1) or (2) must comply with [sections 13 through 21] and the rules implementing [sections
2 13 through 21] by April 1, 1999.

3

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

6

7 **NEW SECTION. Section 23. Quality assurance -- national accreditation.** (1) A health carrier
8 whose managed care plan has been accredited by a nationally recognized accrediting organization shall
9 annually provide a copy of the accreditation and the accrediting standards used by the accrediting
10 organization to the department.

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

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

16 (4) [Section 24] does not apply to a health carrier's managed care plan if the health carrier
17 maintains current accreditation by a nationally recognized accrediting organization whose standards meet
18 or exceed state quality assurance standards adopted pursuant to [sections 23 through 27].

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

21

22 **NEW SECTION. Section 24. Standards for health carrier quality assessment programs.** A health
23 carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure
24 systems sufficient to accurately measure the quality of health care services provided to covered persons
25 on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this
26 requirement, a health carrier shall:

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

30 (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory

1 agencies, providers, and consumers as provided in [section 26];

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

5 (4) file a written description of the quality assessment program and any subsequent material
6 changes with the department in a format that must be prescribed by rules of the department. The
7 description must include a signed certification by a corporate officer of the health carrier that the health
8 carrier's quality assessment program meets the requirements of [sections 23 through 27].

9

10 **NEW SECTION. Section 25. Standards for health carrier quality improvement programs.** A health
11 carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 24],
12 adopt and use systems and methods necessary to improve the quality of health care provided in the health
13 carrier's managed care plan as indicated by the health carrier's quality assessment program and as required
14 by this section. To comply with this requirement, a health carrier subject to this section shall:

15 (1) establish an internal system capable of identifying opportunities to improve care;

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

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

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

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

28

29 **NEW SECTION. Section 26. Reporting and disclosure requirements.** (1) A health carrier offering
30 a closed plan or a combination plan shall document and communicate information, as required in this

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

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

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

6 (c) make available annually to providers and covered persons a report containing findings from its
7 quality assurance program and information about its progress in meeting internal goals and external
8 standards, when available.

9 (2) A health carrier shall certify to the department annually that its quality assurance program and
10 the materials provided to providers and consumers in accordance with subsection (1) meet the requirements
11 of [sections 23 through 27].

12 (3) A health carrier shall make available, upon request and payment of a reasonable fee, the
13 materials certified pursuant to subsection (2), except for the materials subject to the confidentiality
14 requirements of [section 27] and materials that are proprietary to the managed care plan. A health carrier
15 shall retain all certified materials for at least 3 years from the date that the material was certified or until
16 the material has been examined as part of a market conduct examination, whichever is later.

17

18 **NEW SECTION. Section 27. Confidentiality of health care and quality assurance records --**
19 **disclosure.** (1) Except as provided in subsection (2), the following information held by a health carrier
20 offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a
21 person:

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

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

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

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

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

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

5 or

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

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

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

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

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

15

16 **NEW SECTION. Section 28. Enforcement.** (1) If the department determines that a health carrier
17 has not complied with [sections 8 through 29] or the rules implementing [sections 8 through 29], the
18 department may recommend corrective action to the health carrier.

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

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

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

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

26 (d) the commissioner determines that a health carrier has violated or is violating [sections 8 through
27 29] or the rules implementing [sections 8 through 29].

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

30 (a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's

1 application for a certificate of authority; or

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

4

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

7

8 **NEW SECTION. Section 30. Codification instruction.** (1) [Section 7] is intended to be codified as
9 an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 7].

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

12

13 **NEW SECTION. Section 31. Severability.** If a part of [this act] is invalid, all valid parts that are
14 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its
15 applications, the part remains in effect in all valid applications that are severable from the invalid
16 applications.

17

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

21

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

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

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

26

-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:

	<u>FY98</u>	<u>FY99</u>
	<u>Difference</u>	<u>Difference</u>
FTE	1.00	2.00
Personal Services	\$ 34,640	\$ 68,280
Operating Expenses	81,130	77,580
Equipment	<u>4,000</u>	<u>4,000</u>
Total	\$122,470	\$156,260

Funding:

General Fund (01)	\$110,760	\$140,615
Federal Medicaid Funds (03)	<u>11,710</u>	<u>15,645</u>
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

(continued)

State Auditor

Expenditures:

	<u>FY98</u>	<u>FY99</u>
	<u>Difference</u>	<u>Difference</u>
FTE	0.00	1.00
Personal Services		\$ 31,835
Operating Expenses		4,000
Equipment	<u>0</u>	<u>3,585</u>
Total	\$ 0	\$ 39,420

Funding:

General Fund (01)	0	\$ 39,420
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Net Impact on Fund Balance: (Revenue minus Expenses)

General Fund (01)	(\$110,760)	(\$180,035)
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1 SENATE BILL NO. 365

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

7
8 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE
9 CARRIERS WHO OFFER MANAGED CARE PLANS; PROVIDING FOR STATE NETWORK ADEQUACY AND
10 QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING
11 CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE
12 REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; PROVIDING
13 DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE
14 ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL
15 STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE
16 ORGANIZATIONS; CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE
17 EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD; AMENDING
18 SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND
19 PROVIDING EFFECTIVE DATES, AND AN APPLICABILITY DATE, AND A TERMINATION DATE."

20
21 STATEMENT OF INTENT

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

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

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

1 In order to promote uniformity of standards applicable to all managed care plans, state quality
 2 assurance standards for small managed care plans must consist of standards that are ~~at least the equivalent~~
 3 ~~of health plan employer data and information standards. Any other standards adopted must be appropriate~~
 4 for quality assurance in Montana.

5 The department AND SUBSEQUENTLY THE BOARD OF NETWORK ADEQUACY AND QUALITY
 6 ASSURANCE may refer reports of noncompliance by a health carrier to the commissioner for corrective
 7 action. Under the department's rulemaking authority, the department shall specify network adequacy and
 8 quality assurance review processes.

9 [Section 19] designates the department of public health and human services as the place for
 10 insurance carriers to file documents related to managed care provider network adequacy and quality
 11 assurance. The department shall adopt rules establishing procedures for filing these documents and shall
 12 adopt rules specifying processes for amending or withdrawing documents already filed that relate to
 13 network adequacy and quality assurance.

14

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

16

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

18 **"33-22-1703. Definitions.** As used in this part, the following definitions apply:

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

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

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

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

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

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

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

1 ~~(e) a bodily organ or part would be seriously damaged.~~ health care items or services furnished or
 2 required to evaluate and treat an emergency medical condition.

3 ~~(2)(3)~~ "Health benefit plan" means the health insurance policy or subscriber arrangement between
 4 the insured or subscriber and the health care insurer that defines the covered services and benefit levels
 5 available.

6 ~~(3)(4)~~ "Health care insurer" means:

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

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

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

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

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

13 ~~(4)(5)~~ "Health care services" means health care services or products rendered or sold by a provider
 14 within the scope of the provider's license or legal authorization or services provided under Title 33, chapter
 15 22, part 7.

16 ~~(5)(6)~~ "Insured" means an individual entitled to reimbursement for expenses of health care services
 17 under a policy or subscriber contract issued or administered by an insurer.

18 ~~(6)(7)~~ "Preferred provider" means a provider or group of providers who have contracted to provide
 19 specified health care services.

20 ~~(7)(8)~~ "Preferred provider agreement" means a contract between or on behalf of a health care
 21 insurer and a preferred provider.

22 ~~(8)(9)~~ "Provider" means an individual or entity licensed or legally authorized to provide health care
 23 services or services covered within Title 33, chapter 22, part 7.

24 ~~(9)(10)~~ "Subscriber" means a certificate holder or other person on whose behalf the health care
 25 insurer is providing or paying for health care coverage."

26
 27 **Section 2.** Section 33-22-1707, MCA, is amended to read:

28 "**33-22-1707. Rules.** The commissioner ~~shall promulgate~~ may adopt rules necessary to implement
 29 the provisions of this part."

1 **Section 3.** Section 33-31-102, MCA, is amended to read:

2 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the
3 following definitions apply:

4 (1) "Basic health care services" means:

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

6 (b) inpatient hospital and provider care;

7 (c) outpatient medical services;

8 (d) medical treatment and referral services;

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

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

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

13 (h) preventive health services, including:

14 (i) immunizations;

15 (ii) well-child care from birth;

16 (iii) periodic health evaluations for adults;

17 (iv) voluntary family planning services;

18 (v) infertility services; and

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

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

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

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

26 (3) "Enrollee" means a person:

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

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

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

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

3 (5) "Health care services" means:

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

5 (b) the services included in hospitalizing a person;

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

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

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

11 (7) "Health maintenance organization" means a person who provides or arranges for basic health
12 care services to enrollees on a prepaid ~~or other financial~~ basis, either directly through provider employees
13 or through contractual or other arrangements with a provider or a group of providers. This subsection does
14 not limit methods of provider payments made by health maintenance organizations. THIS TERM APPLIES
15 TO PROVIDER-SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES
16 DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING
17 COOPERATIVES.

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

21 (9) "Person" means:

22 (a) an individual;

23 (b) a group of individuals;

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

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

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

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

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

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

6 (12) "PROVIDER-SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS,
 7 HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING
 8 CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A
 9 PHYSICIAN-HOSPITAL ORGANIZATION, A PHYSICIAN-SPONSORED NETWORK, A PHYSICIAN GROUP
 10 PRACTICE, AND A HOSPITAL-PHYSICIAN ORGANIZATION.

11 ~~(12)~~(13) "Uncovered expenditures" mean the costs of health care services that are covered by a
 12 health maintenance organization and for which an enrollee is liable if the health maintenance organization
 13 becomes insolvent."
 14

15 **Section 4.** Section 33-31-111, MCA, is amended to read:

16 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise
 17 provided in this chapter, the insurance or health service corporation laws do not apply to any health
 18 maintenance organization authorized to transact business under this chapter. This provision does not apply
 19 to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
 20 corporation laws of this state except with respect to its health maintenance organization activities
 21 authorized and regulated pursuant to this chapter.

22 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority
 23 or its representatives ~~may not be construed as~~ is not a violation of any law relating to solicitation or
 24 advertising by health professionals.

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

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

29 (5) ~~The provisions of this~~ This section ~~do~~ does not exempt a health maintenance organization from
 30 material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance

1 organization must be considered an insurer for the purposes of 33-3-701 through 33-3-704.

2 (6) This section does not exempt a health maintenance organization from network adequacy and
 3 quality assurance requirements provided under [sections 8 through 29]."

4
 5 **Section 5.** Section 33-31-211, MCA, is amended to read:

6 **"33-31-211. Annual ~~statement~~ statements -- revocation for failure to file -- penalty for false**
 7 **swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized
 8 health maintenance organization shall annually on or before March 1 file with the commissioner a full and
 9 true statement of its financial condition, transactions, and affairs as of the preceding December 31. The
 10 statement must be in the general form and content required by the commissioner. The statement must be
 11 verified by the oath of at least two principal officers of the health maintenance organization. The
 12 commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance
 13 organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file
 14 on or before June 1 an audited financial statement.

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

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

24 (4) The commissioner may require ~~such~~ reports ~~as he considers~~ considered reasonably necessary
 25 and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ his duties required of the commissioner under
 26 this chapter, including but not limited to a statement of operations, transactions, and affairs of a health
 27 maintenance organization operated by an insurer or a health service corporation as a plan."
 28

29 **Section 6.** Section 33-31-216, MCA, is amended to read:

30 **"33-31-216. Protection against insolvency.** (1) Except as provided in subsections (4) through (7),

1 each authorized health maintenance organization shall deposit with the commissioner cash, securities, or
 2 any combination of cash or securities acceptable to the commissioner in the amount set forth in this
 3 section.

4 (2) The amount of the deposit for a health maintenance organization during the first year of its
 5 operation ~~must be the greater of:~~

- 6 ~~(a) 5% of its estimated expenditures for health care services for its first year of operation;~~
 7 ~~(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~
 8 ~~(c) \$100,000 is \$200,000.~~

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

13 (4) Unless not applicable, a health maintenance organization that is in operation on October 1,
 14 1987, shall make a deposit equal to the greater of:

- 15 (a) 1% of the preceding 12 months' uncovered expenditures; or
 16 (b) \$100,000 on the first day of the fiscal year beginning 6 months or more after October 1, 1987.

17 ~~In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its~~
 18 ~~estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must~~
 19 ~~be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and~~
 20 ~~subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual~~
 21 ~~uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably~~
 22 ~~reflect the preceding year's operating experience and delivery arrangements.~~

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

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

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

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

1 its obligations.

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

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

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

30 (9) Unless it is operated by an insurer or a health service corporation as a plan, each health

1 maintenance organization ~~shall~~ must have a minimum capital of at least \$200,000 in addition to any deposit
 2 requirements under this section. The capital account must be in excess of any accrued liabilities and be in
 3 the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

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

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

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

8

9 **NEW SECTION. Section 7. Premium increase restriction -- exception.** (1) A health maintenance
 10 organization may not increase a premium for an individual's or an individual's group health care services
 11 agreement more frequently than once during a 12-month period unless failure to increase the premium more
 12 frequently than once during the 12-month period would:

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

14 (b) cause the financial impairment of the health maintenance organization to the extent that further
 15 transaction of insurance by the health maintenance organization would injure or be hazardous to its
 16 enrollees or to the public.

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

19

20 **NEW SECTION. Section 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care
 21 Plan Network Adequacy and Quality Assurance Act".

22

23 **NEW SECTION. Section 9. Purpose.** The purpose and intent of [sections 8 through 29] are to:

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

29 (2) provide for the implementation of state network adequacy and quality assurance standards in
 30 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for

1 detecting and reporting violations of those standards to the commissioner;

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

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

7 (5) provide a streamlined and simplified process by which managed care network adequacy and
8 quality assurance programs may be monitored for compliance THROUGH COORDINATED EFFORTS OF THE
9 COMMISSIONER AND THE DEPARTMENT [AND THE BOARD]. It is not the purpose or intent of [sections
10 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care
11 plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance
12 programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

13

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

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

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

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

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

23 (5) "Department" means the department of public health and human services established in
24 2-15-2201.

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

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

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

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

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

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

7 (9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered,
8 or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health
9 care services.

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

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

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

16 (13) "Health carrier" means an entity subject to the insurance laws and rules of this state that
17 contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or
18 reimburse any of the costs of health care services, including a disability insurer, health maintenance
19 organization, or health service corporation or another entity providing a health benefit plan.

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

22 (15) "Managed care plan" means a health benefit plan that either requires or creates incentives,
23 including financial incentives, for a covered person to use health care providers managed, owned, under
24 contract with, or employed by a health carrier, but not preferred provider organizations or other provider
25 networks operated in a fee-for-service indemnity environment.

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

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

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

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

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

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

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

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

17
18 **NEW SECTION. Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health
19 carriers that offer managed care plans. [Sections 8 through 29] do not exempt a health carrier from the
20 applicable requirements of federal law when providing a managed care plan to medicare recipients or from
21 the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to
22 medicaid recipients.

23
24 **NEW SECTION. Section 12. Department -- general powers and duties -- rulemaking.** (1) The
25 department shall:

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

29 (b) recommend action to the commissioner **[OR TO THE BOARD]** against a health carrier whose
30 managed care plan does not comply with standards for network adequacy and quality assurance adopted

1 by the department.

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

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

7

8 **NEW SECTION. Section 13. Network adequacy -- standards -- access plan required.** (1) A health
9 carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and
10 types of providers to ensure that all services to covered persons are accessible without unreasonable delay.
11 Sufficiency in number and type of provider is determined in accordance with the requirements of this
12 section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health
13 carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria
14 may include but are not limited to:

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

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

17 (c) geographic accessibility;

18 (d) waiting times for appointments with participating providers;

19 (e) hours of operation; or

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

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

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

30 ~~(4) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial~~

1 ~~capability, and legal authority of its providers to furnish all covered benefits to covered persons.~~

2 ~~(5)(4)~~ A health carrier offering a managed care plan in this state on October 1, 1998, shall file with
3 the department on October 1, 1998, an access plan complying with subsection ~~(7)~~ (6) and the rules of the
4 department. A health carrier offering a managed care plan in this state for the first time after October 1,
5 1998, shall file with the department an access plan meeting the requirements of subsection ~~(7)~~ (6) and the
6 rules of the department before offering the managed care plan. A plan must be filed with the department
7 in a manner and form complying with the rules of the department. A health carrier shall file any subsequent
8 material changes in its access plan with the department within 30 days of implementation of the change.

9 ~~(6)(5)~~ A health carrier may request the department to designate parts of its access plan as
10 proprietary or competitive information, and when designated, that part may not be made public. For the
11 purposes of this section, information is proprietary or competitive if revealing the information would cause
12 the health carrier's competitors to obtain valuable business information. A health carrier shall make the
13 access plans, absent proprietary information, available on its business premises and shall provide a copy
14 of the plan upon request.

15 ~~(7)(6)~~ An access plan for each managed care plan offered in this state must describe or contain
16 at least the following:

- 17 (a) a listing of the names and specialties of the health carrier's participating providers;
- 18 (b) the health carrier's procedures for making referrals within and outside its network;
- 19 (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of
20 the network to meet the health care needs of populations that enroll in the managed care plan;
- 21 (d) the health carrier's efforts to address the needs of covered persons with limited English
22 proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental
23 disabilities;
- 24 (e) the health carrier's methods for assessing the health care needs of covered persons and their
25 satisfaction with services;
- 26 (f) the health carrier's method of informing covered persons of the plan's services and features,
27 including but not limited to the plan's grievance procedures, its process for choosing and changing
28 providers, and its procedures for providing and approving emergency and specialty care;
- 29 (g) the health carrier's system for ensuring the coordination and continuity of care for covered
30 persons referred to specialty physicians and for covered persons using ancillary services, including social

1 services and other community resources, and for ensuring appropriate discharge planning;

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

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

8 (j) any other information required by the department to determine compliance with [sections 13
9 through 21] and the rules implementing [sections 13 through 21].

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

12

13 NEW SECTION. Section 14. Provider responsibility for care -- contracts -- prohibited collection
14 practices. (1) A health carrier offering a managed care plan shall establish a mechanism, described in detail
15 in the contract, by which a participating provider will be notified on an ongoing basis of the covered health
16 care services for which the participating provider is responsible, including any limitations or conditions on
17 those health care services.

18 ~~(2)(1)~~ A contract between a health carrier and a participating provider must set forth a hold
19 harmless provision specifying protection for covered persons. This requirement is met by including in a
20 contract a provision substantially the same as the following:

21 "The provider agrees that the provider may not for any reason, including but not limited to
22 nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach
23 of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or
24 have any recourse from or against a covered person or a person other than the health carrier or intermediary
25 acting on behalf of the covered person for services provided pursuant to this agreement. This agreement
26 does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically
27 provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis
28 to a covered person. This agreement does not prohibit a provider, except a health care professional who
29 is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to
30 that health carrier's covered persons and no others, and a covered person from agreeing to continue

1 services solely at the expense of the covered person if the provider has clearly informed the covered person
 2 that the health carrier may not cover or continue to cover a specific service or services. Except as provided
 3 in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available
 4 for obtaining payment for services from the health carrier."

5 ~~(3)~~(2) A contract between a health carrier and a participating provider must state that if a health
 6 carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered
 7 persons will continue through the end of the period for which a premium has been paid to the health carrier
 8 on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from
 9 an inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an inpatient
 10 facility on the date of insolvency or other cessation of operations must be continued by a provider until the
 11 confinement in an inpatient facility is no longer medically necessary.

12 ~~(4)~~(3) The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2)
 13 must be construed in favor of the covered person, survive the termination of the contract regardless of the
 14 reason for termination, including the insolvency of the health carrier, and supersede an oral or written
 15 contrary agreement between a participating provider and a covered person or the representative of a
 16 covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered
 17 benefits provisions required by subsections ~~(2) and (3)~~ (1) AND (2).

18 ~~(5)~~(4) A participating provider may not collect or attempt to collect from a covered person money
 19 owed to the provider by the health carrier.

20
 21 **NEW SECTION. Section 15. Selection of providers -- professional credentials standards.** (1) A
 22 health carrier shall adopt standards for selecting participating providers who are primary care professionals
 23 and for each health care professional specialty within the health carrier's network. The health carrier shall
 24 use the standards to select health care professionals, the health carrier's intermediaries, and any provider
 25 network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow
 26 the health carrier to:

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

30 (b) exclude a provider because the provider treats or specializes in treating populations presenting

1 a risk of higher than average claims, losses, or use of health care services.

2 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails
3 to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 13
4 through 21] and the rules implementing [sections 13 through 21].

5 (3) [Sections 13 through 21] do not require a health carrier, its intermediary, or a provider network
6 with which the health carrier or its intermediary contract to employ specific providers or types of providers
7 who may meet their selection criteria or to contract with or retain more providers or types of providers than
8 are necessary to maintain an adequate network.

9 (4) A health carrier may use criteria established in accordance with the provisions of this section
10 to select health care professionals allowed to participate in the health carrier's managed care plan. A health
11 carrier shall make its selection standards for participating providers available for review by the department
12 and by each health care professional who is subject to the selection standards.

13

14 **NEW SECTION. Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering
15 a managed care plan shall notify, in writing, prospective participating providers of the participating
16 providers' responsibilities concerning the health carrier's administrative policies and programs, including but
17 not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance
18 procedures, data reporting requirements, confidentiality requirements, and applicable federal or state
19 requirements.

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

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

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

29 (5) A health carrier and participating provider shall provide at least 60 days' written notice to each
30 other before terminating the contract between them without cause. The health carrier shall make a good

1 faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a
2 notice of termination from or to a participating provider, to all covered persons who are patients seen on
3 a regular basis by the participating provider whose contract is terminating, irrespective of whether the
4 termination is for cause or without cause. If a contract termination involves a primary care professional,
5 all covered persons who are patients of that primary care professional must be notified.

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

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

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

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

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

23 (11) A contract between a health carrier and a participating provider may not contain definitions
24 or other provisions that conflict with the definitions or provisions contained in the managed care plan or
25 [sections 8 through 29].

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

30

1 **NEW SECTION. Section 17. Emergency services.** (1) A health carrier offering a managed care plan
2 shall provide or pay for emergency services screening and emergency services and may not require prior
3 authorization for either of those services. If an emergency services screening determines that emergency
4 services or emergency services of a particular type are unnecessary for a covered person, emergency
5 services or emergency services of the type determined unnecessary by the screening need not be covered
6 by the health carrier unless otherwise covered under the health benefit plan. However, if screening
7 determines that emergency services or emergency services of a particular type are necessary, those
8 services must be covered by the health carrier. A health carrier shall cover emergency services if the health
9 carrier, acting through a participating provider or other authorized representative, has authorized the
10 provision of emergency services.

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

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

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

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

25

26 **NEW SECTION. Section 18. Use of intermediaries -- responsibilities of health carriers,**
27 **intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions
28 of [sections 8 through 29], and contracting with an intermediary for all or some of the services for which
29 a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

30 (2) A health carrier may determine whether a subcontracted provider participates in the provider's

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

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

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

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

15 (6) An intermediary shall allow the COMMISSIONER AND THE department access to the
16 intermediary's books, records, claim information, billing information, and other documentation of services
17 provided to covered persons that are required by any of those entities to determine compliance with
18 [sections 13 through 21] and the rules implementing [sections 13 through 21].

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

22
23 **NEW SECTION. Section 19. Contract filing requirements -- material changes -- state access to**
24 **contracts.** (1) On October 1, 1998, a health carrier offering a managed care plan shall file with the
25 department sample contract forms proposed for use with its participating providers and intermediaries.

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

30 (3) A health carrier shall maintain participating provider and intermediary contracts at its principal

1 place of business in this state, or the health carrier must have access to all contracts and provide copies
2 to the department upon 20 days' prior written notice from the department.

3
4 **NEW SECTION. Section 20. General contracting requirements.** (1) The execution of a contract
5 for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty
6 to provide health care services to a person with whom the health carrier has contracted and does not
7 relieve the health carrier of its responsibility for compliance with [sections 8 through 29] or the rules
8 implementing [sections 8 through 29].

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

11
12 **NEW SECTION. Section 21. Contract compliance dates.** (1) A contract between a health carrier
13 and a participating provider or intermediary in effect on October 1, 1997, must comply with [sections 13
14 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department may
15 extend the April 1 date for an additional period of up to 6 months if the health carrier demonstrates good
16 cause for an extension.

17 (2) A contract between a health carrier and a participating provider or intermediary issued or put
18 into effect on or after April 1, 1998, must comply with [sections 13 through 21] and the rules implementing
19 [sections 13 through 21] on the day that it is issued or put into effect.

20 (3) A contract between a health carrier and a participating provider or intermediary not described
21 in subsection (1) or (2) must comply with [sections 13 through 21] and the rules implementing [sections
22 13 through 21] by April 1, 1999.

23
24 **NEW SECTION. Section 22. Department rules.** The department shall adopt rules to implement
25 [sections 13 through 21].

26
27 **NEW SECTION. Section 23. Quality assurance -- national accreditation.** (1) A health carrier
28 whose managed care plan has been accredited by a nationally recognized accrediting organization shall
29 annually provide a copy of the accreditation and the accrediting standards used by the accrediting
30 organization to the department.

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

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

6 (4) [Section 24] does not apply to a health carrier's managed care plan if the health carrier
 7 maintains current accreditation by a nationally recognized accrediting organization whose standards meet
 8 or exceed state quality assurance standards adopted pursuant to [sections 23 through 27].

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

11
 12 **NEW SECTION. Section 24. Standards for health carrier quality assessment programs.** A health
 13 carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure
 14 systems sufficient to accurately measure the quality of health care services provided to covered persons
 15 on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this
 16 requirement, a health carrier shall:

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

20 (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory
 21 agencies, providers, and consumers as provided in [section 26];

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

25 (4) file a written description of the quality assessment program and any subsequent material
 26 changes with the department in a format that must be prescribed by rules of the department. The
 27 description must include a signed certification by a corporate officer of the health carrier that the health
 28 carrier's quality assessment program meets the requirements of [sections 23 through 27].

29
 30 **NEW SECTION. Section 25. Standards for health carrier quality improvement programs.** A health

1 carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 24],
2 adopt and use systems and methods necessary to improve the quality of health care provided in the health
3 carrier's managed care plan as indicated by the health carrier's quality assessment program and as required
4 by this section. To comply with this requirement, a health carrier subject to this section shall:

5 (1) establish an internal system capable of identifying opportunities to improve care;

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

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

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

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

18

19 **NEW SECTION. Section 26. Reporting and disclosure requirements.** (1) A health carrier offering
20 a closed plan or a combination plan shall document and communicate information, as required in this
21 section, about its quality assurance program. The health carrier shall:

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

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

26 (c) make available annually to providers and covered persons a report containing findings from its
27 quality assurance program and information about its progress in meeting internal goals and external
28 standards, when available.

29 (2) A health carrier shall certify to the department annually that its quality assurance program and
30 the materials provided to providers and consumers in accordance with subsection (1) meet the requirements

1 of [sections 23 through 27].

2 (3) A health carrier shall make available, upon request and payment of a reasonable fee, the
3 materials certified pursuant to subsection (2), except for the materials subject to the confidentiality
4 requirements of [section 27] and materials that are proprietary to the managed care plan. A health carrier
5 shall retain all certified materials for at least 3 years from the date that the material was certified or until
6 the material has been examined as part of a market conduct examination, whichever is later.

7

8 **NEW SECTION. Section 27. Confidentiality of health care and quality assurance records --**
9 **disclosure.** (1) Except as provided in subsection (2), the following information held by a health carrier
10 offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a
11 person:

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

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

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

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

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

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

25 or

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

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

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

30 (b) the covered person may also be disclosed upon a written, dated, and signed approval of the

1 covered person or of the parent or guardian of a covered person if the covered person is a minor and if the
2 information does not identify the provider;

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

5

6 **NEW SECTION. Section 28. Enforcement.** (1) If the department [OR THE BOARD] determines that
7 a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through
8 29], the department [OR THE BOARD] may recommend corrective action to the health carrier.

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

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

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

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

18 (d) the commissioner determines that a health carrier has violated or is violating [sections 8 through
19 29] or the rules implementing [sections 8 through 29].

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

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

24 (b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part
25 3.

26

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

29

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

1 FOLLOWING DEFINITIONS APPLY:

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

4 (2) "CLOSED PLAN" MEANS A MANAGED CARE PLAN THAT REQUIRES COVERED PERSONS TO
5 USE ONLY PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.

6 (3) "COMBINATION PLAN" MEANS AN OPEN PLAN WITH A CLOSED COMPONENT.

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

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

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

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

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

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

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

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

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

27 (10) "HEALTH BENEFIT PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT
28 ENTERED INTO, OFFERED, OR ISSUED BY A HEALTH CARRIER TO PROVIDE, DELIVER, ARRANGE FOR,
29 PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

30 (11) "HEALTH CARE PROFESSIONAL" MEANS A PHYSICIAN OR OTHER HEALTH CARE

1 PRACTITIONER LICENSED, ACCREDITED, OR CERTIFIED PURSUANT TO THE LAWS OF THIS STATE TO
2 PERFORM SPECIFIED HEALTH CARE SERVICES CONSISTENT WITH STATE LAW.

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

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

7 (14) "HEALTH CARRIER" MEANS AN ENTITY SUBJECT TO THE INSURANCE LAWS AND RULES
8 OF THIS STATE THAT CONTRACTS, OFFERS TO CONTRACT, OR ENTERS INTO AN AGREEMENT TO
9 PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE
10 SERVICES, INCLUDING A DISABILITY INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH
11 SERVICE CORPORATION OR ANOTHER ENTITY PROVIDING A HEALTH BENEFIT PLAN.

12 (15) "INTERMEDIARY" MEANS A PERSON AUTHORIZED TO NEGOTIATE, EXECUTE, AND BE A
13 PARTY TO A CONTRACT BETWEEN A HEALTH CARRIER AND A PROVIDER OR BETWEEN A HEALTH
14 CARRIER AND A NETWORK.

15 (16) "MANAGED CARE PLAN" MEANS A HEALTH BENEFIT PLAN THAT EITHER REQUIRES OR
16 CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR A COVERED PERSON TO USE HEALTH
17 CARE PROVIDERS MANAGED, OWNED, UNDER CONTRACT WITH, OR EMPLOYED BY A HEALTH
18 CARRIER, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS
19 OPERATED IN A FEE-FOR-SERVICE INDEMNITY ENVIRONMENT.

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

24 (18) "NETWORK" MEANS THE GROUP OF PARTICIPATING PROVIDERS THAT PROVIDES HEALTH
25 CARE SERVICES TO A MANAGED CARE PLAN.

26 (19) "OPEN PLAN" MEANS A MANAGED CARE PLAN OTHER THAN A CLOSED PLAN THAT
27 PROVIDES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR COVERED PERSONS TO USE
28 PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.

29 (20) "PARTICIPATING PROVIDER" MEANS A PROVIDER WHO, UNDER A CONTRACT WITH A
30 HEALTH CARRIER OR WITH THE HEALTH CARRIER'S CONTRACTOR, SUBCONTRACTOR, OR

1 INTERMEDIARY, HAS AGREED TO PROVIDE HEALTH CARE SERVICES TO COVERED PERSONS WITH AN
 2 EXPECTATION OF RECEIVING PAYMENT, OTHER THAN COINSURANCE, COPAYMENTS, OR
 3 DEDUCTIBLES, DIRECTLY OR INDIRECTLY FROM THE HEALTH CARRIER.

4 (21) "PRIMARY CARE PROFESSIONAL" MEANS A PARTICIPATING HEALTH CARE PROFESSIONAL
 5 DESIGNATED BY THE HEALTH CARRIER TO SUPERVISE, COORDINATE, OR PROVIDE INITIAL CARE OR
 6 CONTINUING CARE TO A COVERED PERSON AND WHO MAY BE REQUIRED BY THE HEALTH CARRIER
 7 TO INITIATE A REFERRAL FOR SPECIALTY CARE AND TO MAINTAIN SUPERVISION OF HEALTH CARE
 8 SERVICES RENDERED TO THE COVERED PERSON.

9 (22) "QUALITY ASSESSMENT" MEANS THE MEASUREMENT AND EVALUATION OF THE QUALITY
 10 AND OUTCOMES OF MEDICAL CARE PROVIDED TO INDIVIDUALS, GROUPS, OR POPULATIONS.

11 (23) "QUALITY ASSURANCE" MEANS QUALITY ASSESSMENT AND QUALITY IMPROVEMENT.

12 (24) "QUALITY IMPROVEMENT" MEANS AN EFFORT TO IMPROVE THE PROCESSES AND
 13 OUTCOMES RELATED TO THE PROVISION OF HEALTH CARE SERVICES WITHIN A HEALTH PLAN.

14
 15 NEW SECTION. SECTION 31. BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE.

16 (1) THERE IS A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE. THE BOARD IS
 17 COMPOSED OF A MEDICAL DIRECTOR, THE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND
 18 HUMAN SERVICES, PROVIDED FOR IN 2-15-2201, AND THE COMMISSIONER OF INSURANCE, PROVIDED
 19 FOR IN 2-15-1903.

20 (2) THE MEDICAL DIRECTOR IS APPOINTED BY THE GOVERNOR AND MUST BE LICENSED AS
 21 A PHYSICIAN BY THE STATE OF MONTANA. THE MEDICAL DIRECTOR MUST BE A SPECIALIST IN
 22 EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL
 23 DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.

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

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

27
 28 NEW SECTION. SECTION 32. BOARD -- GENERAL POWERS AND DUTIES. THE BOARD SHALL:

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

1 THROUGH 29];

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

4 (3) RECOMMEND ACTION TO THE COMMISSIONER AGAINST A HEALTH CARRIER WHOSE
5 MANAGED CARE PLAN DOES NOT COMPLY WITH STANDARDS FOR NETWORK ADEQUACY AND
6 QUALITY ASSURANCE ADOPTED BY THE BOARD.

7

8 NEW SECTION. Section 33. Codification instruction. (1) [Section 7] is intended to be codified as
9 an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 7].

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

12

13 NEW SECTION. Section 34. Severability. If a part of [this act] is invalid, all valid parts that are
14 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its
15 applications, the part remains in effect in all valid applications that are severable from the invalid
16 applications.

17

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

21

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

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

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

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

29

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

-END-

1 SENATE BILL NO. 365

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

7
8 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE
9 CARRIERS WHO OFFER MANAGED CARE PLANS; PROVIDING FOR STATE NETWORK ADEQUACY AND
10 QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING
11 CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE
12 REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; PROVIDING
13 DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE
14 ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL
15 STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE
16 ORGANIZATIONS; CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE
17 EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD; AMENDING
18 SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND
19 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.**

1 SENATE BILL NO. 365

2 INTRODUCED BY BENEDICT, HARGROVE, GRIMES, HARP, MERCER, AKLESTAD, AHNER, GROSFIELD,
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15 STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE
16 ORGANIZATIONS; ~~CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE~~
17 ~~EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;~~ AMENDING
18 SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND
19 PROVIDING EFFECTIVE DATES, ~~AND~~ AND AN APPLICABILITY DATE, ~~AND A TERMINATION DATE.~~"

20
21 STATEMENT OF INTENT

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

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

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

1 In order to promote uniformity of standards applicable to all managed care plans, state quality
 2 assurance standards for small managed care plans must consist of standards that are ~~at least the equivalent~~
 3 ~~of health plan employer data and information standards. Any other standards adopted must be appropriate~~
 4 for quality assurance in Montana.

5 The department ~~AND SUBSEQUENTLY THE BOARD OF NETWORK ADEQUACY AND QUALITY~~
 6 ~~ASSURANCE~~ may refer reports of noncompliance by a health carrier to the commissioner for corrective
 7 action. Under the department's rulemaking authority, the department shall specify network adequacy and
 8 quality assurance review processes.

9 [Section 19] designates the department of public health and human services as the place for
 10 insurance carriers to file documents related to managed care provider network adequacy and quality
 11 assurance. The department shall adopt rules establishing procedures for filing these documents and shall
 12 adopt rules specifying processes for amending or withdrawing documents already filed that relate to
 13 network adequacy and quality assurance.

14
 15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

16
 17 **Section 1.** Section 33-22-1703, MCA, is amended to read:

18 **"33-22-1703. Definitions.** As used in this part, the following definitions apply:

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

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

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

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

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

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

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

1 ~~(e) a bodily organ or part would be seriously damaged,~~ health care items or services furnished or
 2 required to evaluate and treat an emergency medical condition.

3 ~~(2)(3)~~ "Health benefit plan" means the health insurance policy or subscriber arrangement between
 4 the insured or subscriber and the health care insurer that defines the covered services and benefit levels
 5 available.

6 ~~(3)(4)~~ "Health care insurer" means:

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

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

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

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

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

13 ~~(4)(5)~~ "Health care services" means health care services or products rendered or sold by a provider
 14 within the scope of the provider's license or legal authorization or services provided under Title 33, chapter
 15 22, part 7.

16 ~~(5)(6)~~ "Insured" means an individual entitled to reimbursement for expenses of health care services
 17 under a policy or subscriber contract issued or administered by an insurer.

18 ~~(6)(7)~~ "Preferred provider" means a provider or group of providers who have contracted to provide
 19 specified health care services.

20 ~~(7)(8)~~ "Preferred provider agreement" means a contract between or on behalf of a health care
 21 insurer and a preferred provider.

22 ~~(8)(9)~~ "Provider" means an individual or entity licensed or legally authorized to provide health care
 23 services or services covered within Title 33, chapter 22, part 7.

24 ~~(9)(10)~~ "Subscriber" means a certificate holder or other person on whose behalf the health care
 25 insurer is providing or paying for health care coverage."

26
 27 **Section 2.** Section 33-22-1707, MCA, is amended to read:

28 **"33-22-1707. Rules.** The commissioner ~~shall promulgate~~ may adopt rules necessary to implement
 29 the provisions of this part."
 30

1 **Section 3.** Section 33-31-102, MCA, is amended to read:

2 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the
3 following definitions apply:

4 (1) "Basic health care services" means:

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

6 (b) inpatient hospital and provider care;

7 (c) outpatient medical services;

8 (d) medical treatment and referral services;

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

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

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

13 (h) preventive health services, including:

14 (i) immunizations;

15 (ii) well-child care from birth;

16 (iii) periodic health evaluations for adults;

17 (iv) voluntary family planning services;

18 (v) infertility services; and

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

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

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

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

26 (3) "Enrollee" means a person:

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

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

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

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

3 (5) "Health care services" means:

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

5 (b) the services included in hospitalizing a person;

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

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

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

11 (7) "Health maintenance organization" means a person who provides or arranges for basic health
12 care services to enrollees on a prepaid ~~or other financial~~ basis, either directly through provider employees
13 or through contractual or other arrangements with a provider or a group of providers. This subsection does
14 not limit methods of provider payments made by health maintenance organizations. THIS TERM APPLIES
15 TO PROVIDER SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES
16 DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING
17 COOPERATIVES.

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

21 (9) "Person" means:

22 (a) an individual;

23 (b) a group of individuals;

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

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

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

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

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

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

6 ~~(12) "PROVIDER SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS,~~
 7 ~~HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING~~
 8 ~~CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A~~
 9 ~~PHYSICIAN HOSPITAL ORGANIZATION, A PHYSICIAN SPONSORED NETWORK, A PHYSICIAN GROUP~~
 10 ~~PRACTICE, AND A HOSPITAL PHYSICIAN ORGANIZATION.~~

11 ~~(12)(13)(12)~~ "Uncovered expenditures" mean the costs of health care services that are covered by
 12 a health maintenance organization and for which an enrollee is liable if the health maintenance organization
 13 becomes insolvent."
 14

15 **Section 4.** Section 33-31-111, MCA, is amended to read:

16 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise
 17 provided in this chapter, the insurance or health service corporation laws do not apply to any health
 18 maintenance organization authorized to transact business under this chapter. This provision does not apply
 19 to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
 20 corporation laws of this state except with respect to its health maintenance organization activities
 21 authorized and regulated pursuant to this chapter.

22 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority
 23 or its representatives ~~may not be construed as~~ is not a violation of any law relating to solicitation or
 24 advertising by health professionals.

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

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

29 (5) ~~The provisions of this~~ This section ~~do~~ does not exempt a health maintenance organization from
 30 material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance

1 organization must be considered an insurer for the purposes of 33-3-701 through 33-3-704.

2 (6) This section does not exempt a health maintenance organization from network adequacy and
 3 quality assurance requirements provided under [sections 8 through 29]."

4

5 **Section 5.** Section 33-31-211, MCA, is amended to read:

6 **"33-31-211. Annual ~~statement~~ statements -- revocation for failure to file -- penalty for false**
 7 **swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized
 8 health maintenance organization shall annually on or before March 1 file with the commissioner a full and
 9 true statement of its financial condition, transactions, and affairs as of the preceding December 31. The
 10 statement must be in the general form and content required by the commissioner. The statement must be
 11 verified by the oath of at least two principal officers of the health maintenance organization. The
 12 commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance
 13 organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file
 14 on or before June 1 an audited financial statement.

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

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

24 (4) The commissioner may require ~~such~~ reports ~~as he considers~~ considered reasonably necessary
 25 and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ required of the commissioner under
 26 this chapter, including but not limited to a statement of operations, transactions, and affairs of a health
 27 maintenance organization operated by an insurer or a health service corporation as a plan."
 28

29 **Section 6.** Section 33-31-216, MCA, is amended to read:

30 **"33-31-216. Protection against insolvency.** (1) Except as provided in subsections (4) through (7),

1 each authorized health maintenance organization shall deposit with the commissioner cash, securities, or
 2 any combination of cash or securities acceptable to the commissioner in the amount set forth in this
 3 section.

4 (2) The amount of the deposit for a health maintenance organization during the first year of its
 5 operation ~~must be the greater of:~~

- 6 ~~(a) 5% of its estimated expenditures for health care services for its first year of operation;~~
 7 ~~(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~
 8 ~~(c) \$100,000 is \$200,000.~~

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

13 (4) Unless not applicable, a health maintenance organization that is in operation on October 1,
 14 1987, shall make a deposit equal to the greater of:

- 15 (a) 1% of the preceding 12 months' uncovered expenditures; or
 16 (b) ~~\$100,000 on the first day of the fiscal year beginning 6 months or more after October 1, 1987.~~
 17 ~~In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its~~
 18 ~~estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must~~
 19 ~~be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and~~
 20 ~~subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual~~
 21 ~~uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably~~
 22 ~~reflect the preceding year's operating experience and delivery arrangements.~~

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

- 25 (a) the health maintenance organization has sufficient net worth and an adequate history of
 26 generating net income to ~~assure~~ ensure its financial viability for the next year;
 27 (b) the health maintenance organization's performance and obligations are guaranteed by an
 28 organization with sufficient net worth and an adequate history of generating net income; or
 29 (c) the health maintenance organization's assets or its contracts with insurers, health service
 30 corporations, governments, or other organizations are reasonably sufficient to assure the performance of

1 its obligations.

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

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

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

30 (9) Unless it is operated by an insurer or a health service corporation as a plan, each health

1 maintenance organization ~~shall~~ must have a minimum capital of at least \$200,000 in addition to any deposit
 2 requirements under this section. The capital account must be in excess of any accrued liabilities and be in
 3 the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

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

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

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

8

9 **NEW SECTION. Section 7. Premium increase restriction -- exception.** (1) A health maintenance
 10 organization may not increase a premium for an individual's or an individual's group health care services
 11 agreement more frequently than once during a 12-month period unless failure to increase the premium more
 12 frequently than once during the 12-month period would:

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

14 (b) cause the financial impairment of the health maintenance organization to the extent that further
 15 transaction of insurance by the health maintenance organization would injure or be hazardous to its
 16 enrollees or to the public.

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

19

20 **NEW SECTION. Section 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care
 21 Plan Network Adequacy and Quality Assurance Act".

22

23 **NEW SECTION. Section 9. Purpose.** The purpose and intent of [sections 8 through 29] are to:

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

29 (2) provide for the implementation of state network adequacy and quality assurance standards in
 30 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for

1 detecting and reporting violations of those standards to the commissioner;

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

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

7 (5) provide a streamlined and simplified process by which managed care network adequacy and
8 quality assurance programs may be monitored for compliance THROUGH COORDINATED EFFORTS OF THE
9 COMMISSIONER AND THE DEPARTMENT ~~(AND THE BOARD)~~. It is not the purpose or intent of [sections
10 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care
11 plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance
12 programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

13

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

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

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

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

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

23 (5) "Department" means the department of public health and human services established in
24 2-15-2201.

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

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

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

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

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

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

7 (9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered,
8 or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health
9 care services.

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

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

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

16 (13) "Health carrier" means an entity subject to the insurance laws and rules of this state that
17 contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or
18 reimburse any of the costs of health care services, including a disability insurer, health maintenance
19 organization, or health service corporation or another entity providing a health benefit plan.

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

22 (15) "Managed care plan" means a health benefit plan that either requires or creates incentives,
23 including financial incentives, for a covered person to use health care providers managed, owned, under
24 contract with, or employed by a health carrier, but not preferred provider organizations or other provider
25 networks operated in a fee-for-service indemnity environment.

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

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

1 a managed care plan.

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

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

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

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

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

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

18

19 **NEW SECTION. Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health
20 carriers that offer managed care plans. [Sections 8 through 29] do not exempt a health carrier from the
21 applicable requirements of federal law when providing a managed care plan to medicare recipients or from
22 the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to
23 medicaid recipients.

24

25 **NEW SECTION. Section 12. Department -- general powers and duties -- rulemaking.** (1) The
26 department shall:

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

30 (b) recommend action to the commissioner ~~[OR TO THE BOARD]~~ against a health carrier whose

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

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

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

8

9 **NEW SECTION. Section 13. Network adequacy -- standards -- access plan required.** (1) A health
10 carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and
11 types of providers to ensure that all services to covered persons are accessible without unreasonable delay.
12 Sufficiency in number and type of provider is determined in accordance with the requirements of this
13 section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health
14 carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria
15 may include but are not limited to:

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

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

18 (c) geographic accessibility;

19 (d) waiting times for appointments with participating providers;

20 (e) hours of operation; or

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

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

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

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

3 ~~(5)~~(4) A health carrier offering a managed care plan in this state on October 1, 1998, shall file with
4 the department on October 1, 1998, an access plan complying with subsection ~~(7)~~ (6) and the rules of the
5 department. A health carrier offering a managed care plan in this state for the first time after October 1,
6 1998, shall file with the department an access plan meeting the requirements of subsection ~~(7)~~ (6) and the
7 rules of the department before offering the managed care plan. A plan must be filed with the department
8 in a manner and form complying with the rules of the department. A health carrier shall file any subsequent
9 material changes in its access plan with the department within 30 days of implementation of the change.

10 ~~(6)~~(5) A health carrier may request the department to designate parts of its access plan as
11 proprietary or competitive information, and when designated, that part may not be made public. For the
12 purposes of this section, information is proprietary or competitive if revealing the information would cause
13 the health carrier's competitors to obtain valuable business information. A health carrier shall make the
14 access plans, absent proprietary information, available on its business premises and shall provide a copy
15 of the plan upon request.

16 ~~(7)~~(6) An access plan for each managed care plan offered in this state must describe or contain
17 at least the following:

- 18 (a) a listing of the names and specialties of the health carrier's participating providers;
- 19 (b) the health carrier's procedures for making referrals within and outside its network;
- 20 (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of
21 the network to meet the health care needs of populations that enroll in the managed care plan;
- 22 (d) the health carrier's efforts to address the needs of covered persons with limited English
23 proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental
24 disabilities;
- 25 (e) the health carrier's methods for assessing the health care needs of covered persons and their
26 satisfaction with services;
- 27 (f) the health carrier's method of informing covered persons of the plan's services and features,
28 including but not limited to the plan's grievance procedures, its process for choosing and changing
29 providers, and its procedures for providing and approving emergency and specialty care;
- 30 (g) the health carrier's system for ensuring the coordination and continuity of care for covered

1 persons referred to specialty physicians and for covered persons using ancillary services, including social
 2 services and other community resources, and for ensuring appropriate discharge planning;

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

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

9 (j) any other information required by the department to determine compliance with [sections 13
 10 through 21] and the rules implementing [sections 13 through 21].

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

13
 14 NEW SECTION. Section 14. Provider responsibility for care -- contracts -- prohibited collection
 15 practices. (1) A health carrier offering a managed care plan shall establish a mechanism, described in detail
 16 in the contract, by which a participating provider will be notified on an ongoing basis of the covered health
 17 care services for which the participating provider is responsible, including any limitations or conditions on
 18 those health care services.

19 ~~(2)~~(1) A contract between a health carrier and a participating provider must set forth a hold
 20 harmless provision specifying protection for covered persons. This requirement is met by including in a
 21 contract a provision substantially the same as the following:

22 "The provider agrees that the provider may not for any reason, including but not limited to
 23 nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach
 24 of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or
 25 have any recourse from or against a covered person or a person other than the health carrier or intermediary
 26 acting on behalf of the covered person for services provided pursuant to this agreement. This agreement
 27 does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically
 28 provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis
 29 to a covered person. This agreement does not prohibit a provider, except a health care professional who
 30 is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to

1 that health carrier's covered persons and no others, and a covered person from agreeing to continue
 2 services solely at the expense of the covered person if the provider has clearly informed the covered person
 3 that the health carrier may not cover or continue to cover a specific service or services. Except as provided
 4 in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available
 5 for obtaining payment for services from the health carrier."

6 ~~(3)(2)~~ A contract between a health carrier and a participating provider must state that if a health
 7 carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered
 8 persons will continue through the end of the period for which a premium has been paid to the health carrier
 9 on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from
 10 an ACUTE CARE inpatient facility, whichever occurs last. Covered benefits to a covered person confined
 11 in an ACUTE CARE inpatient facility on the date of insolvency or other cessation of operations must be
 12 continued by a provider until the confinement in an inpatient facility is no longer medically necessary.

13 ~~(4)(3)~~ The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2)
 14 must be construed in favor of the covered person, survive the termination of the contract regardless of the
 15 reason for termination, including the insolvency of the health carrier, and supersede an oral or written
 16 contrary agreement between a participating provider and a covered person or the representative of a
 17 covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered
 18 benefits provisions required by subsections ~~(2) and (3)~~ (1) AND (2).

19 ~~(5)(4)~~ A participating provider may not collect or attempt to collect from a covered person money
 20 owed to the provider by the health carrier.

21

22 **NEW SECTION. Section 15. Selection of providers -- professional credentials standards.** (1) A
 23 health carrier shall adopt standards for selecting participating providers who are primary care professionals
 24 and for each health care professional specialty within the health carrier's network. The health carrier shall
 25 use the standards to select health care professionals, the health carrier's intermediaries, and any provider
 26 network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow
 27 the health carrier to:

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

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

3 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails
4 to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 13
5 through 21] and the rules implementing [sections 13 through 21].

6 (3) [Sections 13 through 21] do not require a health carrier, its intermediary, or a provider network
7 with which the health carrier or its intermediary contract to employ specific providers or types of providers
8 who may meet their selection criteria or to contract with or retain more providers or types of providers than
9 are necessary to maintain an adequate network.

10 (4) A health carrier may use criteria established in accordance with the provisions of this section
11 to select health care professionals allowed to participate in the health carrier's managed care plan. A health
12 carrier shall make its selection standards for participating providers available for review by the department
13 and by each health care professional who is subject to the selection standards.

14
15 **NEW SECTION. Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering
16 a managed care plan shall notify, in writing, prospective participating providers of the participating
17 providers' responsibilities concerning the health carrier's administrative policies and programs, including but
18 not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance
19 procedures, data reporting requirements, confidentiality requirements, and applicable federal or state
20 requirements.

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

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

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

30 (5) A health carrier and participating provider shall provide at least 60 days' written notice to each

1 other before terminating the contract between them without cause. The health carrier shall make a good
2 faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a
3 notice of termination from or to a participating provider, to all covered persons who are patients seen on
4 a regular basis by the participating provider whose contract is terminating, irrespective of whether the
5 termination is for cause or without cause. If a contract termination involves a primary care professional,
6 all covered persons who are patients of that primary care professional must be notified.

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

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

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

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

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

24 (11) A contract between a health carrier and a participating provider may not contain definitions
25 or other provisions that conflict with the definitions or provisions contained in the managed care plan or
26 [sections 8 through 29].

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

1 **NEW SECTION. Section 17. Emergency services.** (1) A health carrier offering a managed care plan
 2 shall provide or pay for emergency services screening and emergency services and may not require prior
 3 authorization for either of those services. If an emergency services screening determines that emergency
 4 services or emergency services of a particular type are unnecessary for a covered person, emergency
 5 services or emergency services of the type determined unnecessary by the screening need not be covered
 6 by the health carrier unless otherwise covered under the health benefit plan. However, if screening
 7 determines that emergency services or emergency services of a particular type are necessary, those
 8 services must be covered by the health carrier. A health carrier shall cover emergency services if the health
 9 carrier, acting through a participating provider or other authorized representative, has authorized the
 10 provision of emergency services.

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

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

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

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

25
 26 **NEW SECTION. Section 18. Use of intermediaries -- responsibilities of health carriers,**
 27 **intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions
 28 of [sections 8 through 29], and contracting with an intermediary for all or some of the services for which
 29 a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

30 (2) A health carrier may determine whether a subcontracted provider participates in the provider's

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

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

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

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

15 (6) An intermediary shall allow the COMMISSIONER AND THE department access to the
16 intermediary's books, records, claim information, billing information, and other documentation of services
17 provided to covered persons that are required by any of those entities to determine compliance with
18 [sections 13 through 21] and the rules implementing [sections 13 through 21].

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

22

23 NEW SECTION. **Section 19. Contract filing requirements -- material changes -- state access to**
24 **contracts.** (1) On October 1, 1998, a health carrier offering a managed care plan shall file with the
25 department sample contract forms proposed for use with its participating providers and intermediaries.

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

30 (3) A health carrier shall maintain participating provider and intermediary contracts at its principal

1 place of business in this state, or the health carrier must have access to all contracts and provide copies
2 to the department upon 20 days' prior written notice from the department.

3
4 **NEW SECTION. Section 20. General contracting requirements.** (1) The execution of a contract
5 for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty
6 to provide health care services to a person with whom the health carrier has contracted and does not
7 relieve the health carrier of its responsibility for compliance with [sections 8 through 29] or the rules
8 implementing [sections 8 through 29].

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

11
12 **NEW SECTION. Section 21. Contract compliance dates.** (1) A contract between a health carrier
13 and a participating provider or intermediary in effect on October 1, 1997, must comply with [sections 13
14 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department may
15 extend the April 1 date for an additional period of up to 6 months if the health carrier demonstrates good
16 cause for an extension.

17 (2) A contract between a health carrier and a participating provider or intermediary issued or put
18 into effect on or after April 1, 1998, must comply with [sections 13 through 21] and the rules implementing
19 [sections 13 through 21] on the day that it is issued or put into effect.

20 (3) A contract between a health carrier and a participating provider or intermediary not described
21 in subsection (1) or (2) must comply with [sections 13 through 21] and the rules implementing [sections
22 13 through 21] by April 1, 1999.

23
24 **NEW SECTION. Section 22. Department rules.** The department shall adopt rules to implement
25 [sections 13 through 21].

26
27 **NEW SECTION. Section 23. Quality assurance -- national accreditation.** (1) A health carrier
28 whose managed care plan has been accredited by a nationally recognized accrediting organization shall
29 annually provide a copy of the accreditation and the accrediting standards used by the accrediting
30 organization to the department.

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

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

6 (4) [Section 24] does not apply to a health carrier’s managed care plan if the health carrier
7 maintains current accreditation by a nationally recognized accrediting organization whose standards meet
8 or exceed state quality assurance standards adopted pursuant to [sections 23 through 27].

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

11

12 **NEW SECTION. Section 24. Standards for health carrier quality assessment programs.** A health
13 carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure
14 systems sufficient to accurately measure the quality of health care services provided to covered persons
15 on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this
16 requirement, a health carrier shall:

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

20 (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory
21 agencies, providers, and consumers as provided in [section 26];

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

25 (4) file a written description of the quality assessment program and any subsequent material
26 changes with the department in a format that must be prescribed by rules of the department. The
27 description must include a signed certification by a corporate officer of the health carrier that the health
28 carrier’s quality assessment program meets the requirements of [sections 23 through 27].

29

30 **NEW SECTION. Section 25. Standards for health carrier quality improvement programs.** A health

1 carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 24],
2 adopt and use systems and methods necessary to improve the quality of health care provided in the health
3 carrier's managed care plan as indicated by the health carrier's quality assessment program and as required
4 by this section. To comply with this requirement, a health carrier subject to this section shall:

5 (1) establish an internal system capable of identifying opportunities to improve care;

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

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

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

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

18

19 **NEW SECTION. Section 26. Reporting and disclosure requirements.** (1) A health carrier offering
20 a closed plan or a combination plan shall document and communicate information, as required in this
21 section, about its quality assurance program. The health carrier shall:

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

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

26 (c) make available annually to providers and covered persons a report containing findings from its
27 quality assurance program and information about its progress in meeting internal goals and external
28 standards, when available.

29 (2) A health carrier shall certify to the department annually that its quality assurance program and
30 the materials provided to providers and consumers in accordance with subsection (1) meet the requirements

1 of [sections 23 through 27].

2 (3) A health carrier shall make available, upon request and payment of a reasonable fee, the
3 materials certified pursuant to subsection (2), except for the materials subject to the confidentiality
4 requirements of [section 27] and materials that are proprietary to the managed care plan. A health carrier
5 shall retain all certified materials for at least 3 years from the date that the material was certified or until
6 the material has been examined as part of a market conduct examination, whichever is later.

7

8 **NEW SECTION. Section 27. Confidentiality of health care and quality assurance records --**
9 **disclosure.** (1) Except as provided in subsection (2), the following information held by a health carrier
10 offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a
11 person:

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

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

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

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

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

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

25 or

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

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

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

30 (b) the covered person may also be disclosed upon a written, dated, and signed approval of the

1 covered person or of the parent or guardian of a covered person if the covered person is a minor and if the
 2 information does not identify the provider;

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

5

6 **NEW SECTION. Section 28. Enforcement.** (1) If the department ~~[OR THE BOARD]~~ determines that
 7 a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through
 8 29], the department ~~[OR THE BOARD]~~ may recommend corrective action to the health carrier.

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

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

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

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

18 (d) the commissioner determines that a health carrier has violated or is violating [sections 8 through
 19 29] or the rules implementing [sections 8 through 29].

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

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

24 (b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part
 25 3.

26

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

29

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

1 FOLLOWING DEFINITIONS APPLY:

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

4 (2) "CLOSED PLAN" MEANS A MANAGED CARE PLAN THAT REQUIRES COVERED PERSONS TO
5 USE ONLY PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.

6 (3) "COMBINATION PLAN" MEANS AN OPEN PLAN WITH A CLOSED COMPONENT.

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

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

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

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

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

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

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

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

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

27 (10) "HEALTH BENEFIT PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT
28 ENTERED INTO, OFFERED, OR ISSUED BY A HEALTH CARRIER TO PROVIDE, DELIVER, ARRANGE FOR,
29 PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.

30 (11) "HEALTH CARE PROFESSIONAL" MEANS A PHYSICIAN OR OTHER HEALTH CARE

1 ~~PRACTITIONER LICENSED, ACCREDITED, OR CERTIFIED PURSUANT TO THE LAWS OF THIS STATE TO~~
2 ~~PERFORM SPECIFIED HEALTH CARE SERVICES CONSISTENT WITH STATE LAW.~~

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

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

7 ~~(14) "HEALTH CARRIER" MEANS AN ENTITY SUBJECT TO THE INSURANCE LAWS AND RULES~~
8 ~~OF THIS STATE THAT CONTRACTS, OFFERS TO CONTRACT, OR ENTERS INTO AN AGREEMENT TO~~
9 ~~PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE~~
10 ~~SERVICES, INCLUDING A DISABILITY INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH~~
11 ~~SERVICE CORPORATION OR ANOTHER ENTITY PROVIDING A HEALTH BENEFIT PLAN.~~

12 ~~(15) "INTERMEDIARY" MEANS A PERSON AUTHORIZED TO NEGOTIATE, EXECUTE, AND BE A~~
13 ~~PARTY TO A CONTRACT BETWEEN A HEALTH CARRIER AND A PROVIDER OR BETWEEN A HEALTH~~
14 ~~CARRIER AND A NETWORK.~~

15 ~~(16) "MANAGED CARE PLAN" MEANS A HEALTH BENEFIT PLAN THAT EITHER REQUIRES OR~~
16 ~~CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR A COVERED PERSON TO USE HEALTH~~
17 ~~CARE PROVIDERS MANAGED, OWNED, UNDER CONTRACT WITH, OR EMPLOYED BY A HEALTH~~
18 ~~CARRIER, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS~~
19 ~~OPERATED IN A FEE-FOR-SERVICE INDEMNITY ENVIRONMENT.~~

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

24 ~~(18) "NETWORK" MEANS THE GROUP OF PARTICIPATING PROVIDERS THAT PROVIDES HEALTH~~
25 ~~CARE SERVICES TO A MANAGED CARE PLAN.~~

26 ~~(19) "OPEN PLAN" MEANS A MANAGED CARE PLAN OTHER THAN A CLOSED PLAN THAT~~
27 ~~PROVIDES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR COVERED PERSONS TO USE~~
28 ~~PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.~~

29 ~~(20) "PARTICIPATING PROVIDER" MEANS A PROVIDER WHO, UNDER A CONTRACT WITH A~~
30 ~~HEALTH CARRIER OR WITH THE HEALTH CARRIER'S CONTRACTOR, SUBCONTRACTOR, OR~~

1 ~~INTERMEDIARY, HAS AGREED TO PROVIDE HEALTH CARE SERVICES TO COVERED PERSONS WITH AN~~
 2 ~~EXPECTATION OF RECEIVING PAYMENT, OTHER THAN COINSURANCE, COPAYMENTS, OR~~
 3 ~~DEDUCTIBLES, DIRECTLY OR INDIRECTLY FROM THE HEALTH CARRIER.~~

4 ~~(21) "PRIMARY CARE PROFESSIONAL" MEANS A PARTICIPATING HEALTH CARE PROFESSIONAL~~
 5 ~~DESIGNATED BY THE HEALTH CARRIER TO SUPERVISE, COORDINATE, OR PROVIDE INITIAL CARE OR~~
 6 ~~CONTINUING CARE TO A COVERED PERSON AND WHO MAY BE REQUIRED BY THE HEALTH CARRIER~~
 7 ~~TO INITIATE A REFERRAL FOR SPECIALTY CARE AND TO MAINTAIN SUPERVISION OF HEALTH CARE~~
 8 ~~SERVICES RENDERED TO THE COVERED PERSON.~~

9 ~~(22) "QUALITY ASSESSMENT" MEANS THE MEASUREMENT AND EVALUATION OF THE QUALITY~~
 10 ~~AND OUTCOMES OF MEDICAL CARE PROVIDED TO INDIVIDUALS, GROUPS, OR POPULATIONS.~~

11 ~~(23) "QUALITY ASSURANCE" MEANS QUALITY ASSESSMENT AND QUALITY IMPROVEMENT.~~

12 ~~(24) "QUALITY IMPROVEMENT" MEANS AN EFFORT TO IMPROVE THE PROCESSES AND~~
 13 ~~OUTCOMES RELATED TO THE PROVISION OF HEALTH CARE SERVICES WITHIN A HEALTH PLAN.~~

14
 15 ~~NEW SECTION. SECTION 31. BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE.~~

16 ~~(1) THERE IS A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE. THE BOARD IS~~
 17 ~~COMPOSED OF A MEDICAL DIRECTOR, THE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND~~
 18 ~~HUMAN SERVICES, PROVIDED FOR IN 2-15-2201, AND THE COMMISSIONER OF INSURANCE, PROVIDED~~
 19 ~~FOR IN 2-15-1903.~~

20 ~~(2) THE MEDICAL DIRECTOR IS APPOINTED BY THE GOVERNOR AND MUST BE LICENSED AS~~
 21 ~~A PHYSICIAN BY THE STATE OF MONTANA. THE MEDICAL DIRECTOR MUST BE A SPECIALIST IN~~
 22 ~~EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL~~
 23 ~~DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.~~

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

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

27
 28 ~~NEW SECTION. SECTION 32. BOARD -- GENERAL POWERS AND DUTIES. THE BOARD SHALL:~~

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

1 ~~THROUGH 29];~~

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

4 ~~(3) RECOMMEND ACTION TO THE COMMISSIONER AGAINST A HEALTH CARRIER WHOSE~~
5 ~~MANAGED CARE PLAN DOES NOT COMPLY WITH STANDARDS FOR NETWORK ADEQUACY AND~~
6 ~~QUALITY ASSURANCE ADOPTED BY THE BOARD.~~

7
8 **NEW SECTION. Section 30. Codification instruction.** (1) [Section 7] is intended to be codified as
9 an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 7].

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

12
13 **NEW SECTION. Section 31. Severability.** If a part of [this act] is invalid, all valid parts that are
14 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its
15 applications, the part remains in effect in all valid applications that are severable from the invalid
16 applications.

17
18 **NEW SECTION. Section 32. Applicability.** [This act] applies to a health carrier as defined in
19 [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of
20 this section].

21
22 **NEW SECTION. Section 33. Effective dates.** (1) Except as provided in subsections (2) and (3),
23 [this act] is effective January 1, 1998.

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

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

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

29
30 ~~NEW SECTION. SECTION 37. TERMINATION. [SECTION 10] TERMINATES JUNE 30, 2001.~~

-END-

1 SENATE BILL NO. 365

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

7
 8 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE
 9 CARRIERS WHO OFFER MANAGED CARE PLANS; PROVIDING FOR STATE NETWORK ADEQUACY AND
 10 QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING
 11 CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE
 12 REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; PROVIDING
 13 DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE
 14 ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL
 15 STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE
 16 ORGANIZATIONS; ~~CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE~~
 17 ~~EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;~~ AMENDING
 18 SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND
 19 PROVIDING EFFECTIVE DATES, ~~AND AND AN APPLICABILITY DATE, AND A TERMINATION DATE."~~

20
21 STATEMENT OF INTENT

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

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

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

1 In order to promote uniformity of standards applicable to all managed care plans, state quality
 2 assurance standards for small managed care plans must consist of standards that are ~~at least the equivalent~~
 3 ~~of health plan employer data and information standards. Any other standards adopted must be~~ appropriate
 4 for quality assurance in Montana.

5 The department ~~AND SUBSEQUENTLY THE BOARD OF NETWORK ADEQUACY AND QUALITY~~
 6 ~~ASSURANCE~~ may refer reports of noncompliance by a health carrier to the commissioner for corrective
 7 action. Under the department's rulemaking authority, the department shall specify network adequacy and
 8 quality assurance review processes.

9 [Section 19] designates the department of public health and human services as the place for
 10 insurance carriers to file documents related to managed care provider network adequacy and quality
 11 assurance. The department shall adopt rules establishing procedures for filing these documents and shall
 12 adopt rules specifying processes for amending or withdrawing documents already filed that relate to
 13 network adequacy and quality assurance.

14
 15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

16
 17 **Section 1.** Section 33-22-1703, MCA, is amended to read:

18 **"33-22-1703. Definitions.** As used in this part, the following definitions apply:

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

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

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

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

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

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

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

1 ~~(c) a bodily organ or part would be seriously damaged.~~ health care items or services furnished or
2 required to evaluate and treat an emergency medical condition.

3 ~~(2)(3)~~ "Health benefit plan" means the health insurance policy or subscriber arrangement between
4 the insured or subscriber and the health care insurer that defines the covered services and benefit levels
5 available.

6 ~~(3)(4)~~ "Health care insurer" means:

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

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

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

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

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

13 ~~(4)(5)~~ "Health care services" means health care services or products rendered or sold by a provider
14 within the scope of the provider's license or legal authorization or services provided under Title 33, chapter
15 22, part 7.

16 ~~(5)(6)~~ "Insured" means an individual entitled to reimbursement for expenses of health care services
17 under a policy or subscriber contract issued or administered by an insurer.

18 ~~(6)(7)~~ "Preferred provider" means a provider or group of providers who have contracted to provide
19 specified health care services.

20 ~~(7)(8)~~ "Preferred provider agreement" means a contract between or on behalf of a health care
21 insurer and a preferred provider.

22 ~~(8)(9)~~ "Provider" means an individual or entity licensed or legally authorized to provide health care
23 services or services covered within Title 33, chapter 22, part 7.

24 ~~(9)(10)~~ "Subscriber" means a certificate holder or other person on whose behalf the health care
25 insurer is providing or paying for health care coverage."
26

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

28 **"33-22-1707. Rules.** The commissioner ~~shall promulgate~~ may adopt rules necessary to implement
29 the provisions of this part."
30

1 **Section 3.** Section 33-31-102, MCA, is amended to read:

2 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the
3 following definitions apply:

4 (1) "Basic health care services" means:

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

6 (b) inpatient hospital and provider care;

7 (c) outpatient medical services;

8 (d) medical treatment and referral services;

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

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

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

13 (h) preventive health services, including:

14 (i) immunizations;

15 (ii) well-child care from birth;

16 (iii) periodic health evaluations for adults;

17 (iv) voluntary family planning services;

18 (v) infertility services; and

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

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

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

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

26 (3) "Enrollee" means a person:

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

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

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

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

3 (5) "Health care services" means:

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

5 (b) the services included in hospitalizing a person;

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

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

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

11 (7) "Health maintenance organization" means a person who provides or arranges for basic health
12 care services to enrollees on a prepaid ~~or other financial~~ basis, either directly through provider employees
13 or through contractual or other arrangements with a provider or a group of providers. This subsection does
14 not limit methods of provider payments made by health maintenance organizations. THIS TERM APPLIES
15 TO PROVIDER SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES
16 DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING
17 COOPERATIVES.

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

21 (9) "Person" means:

22 (a) an individual;

23 (b) a group of individuals;

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

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

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

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

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

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

6 ~~(12) "PROVIDER SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS,~~
 7 ~~HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING~~
 8 ~~CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A~~
 9 ~~PHYSICIAN HOSPITAL ORGANIZATION, A PHYSICIAN SPONSORED NETWORK, A PHYSICIAN GROUP~~
 10 ~~PRACTICE, AND A HOSPITAL PHYSICIAN ORGANIZATION.~~

11 ~~(12)(13)(12)~~ (12) "Uncovered expenditures" mean the costs of health care services that are covered by
 12 a health maintenance organization and for which an enrollee is liable if the health maintenance organization
 13 becomes insolvent."

14

15 **Section 4.** Section 33-31-111, MCA, is amended to read:

16 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise
 17 provided in this chapter, the insurance or health service corporation laws do not apply to any health
 18 maintenance organization authorized to transact business under this chapter. This provision does not apply
 19 to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
 20 corporation laws of this state except with respect to its health maintenance organization activities
 21 authorized and regulated pursuant to this chapter.

22 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority
 23 or its representatives ~~may not be construed as~~ is not a violation of any law relating to solicitation or
 24 advertising by health professionals.

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

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

29 (5) ~~The provisions of this~~ This section ~~do~~ does not exempt a health maintenance organization from
 30 material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance

1 organization must be considered an insurer for the purposes of 33-3-701 through 33-3-704.

2 (6) This section does not exempt a health maintenance organization from network adequacy and
 3 quality assurance requirements provided under [sections 8 through 29]."

4
 5 **Section 5.** Section 33-31-211, MCA, is amended to read:

6 **"33-31-211. Annual ~~statement~~ statements -- revocation for failure to file -- penalty for false**
 7 **swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized
 8 health maintenance organization shall annually on or before March 1 file with the commissioner a full and
 9 true statement of its financial condition, transactions, and affairs as of the preceding December 31. The
 10 statement must be in the general form and content required by the commissioner. The statement must be
 11 verified by the oath of at least two principal officers of the health maintenance organization. The
 12 commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance
 13 organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file
 14 on or before June 1 an audited financial statement.

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

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

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

28
 29 **Section 6.** Section 33-31-216, MCA, is amended to read:

30 **"33-31-216. Protection against insolvency.** (1) Except as provided in subsections (4) through (7),

1 each authorized health maintenance organization shall deposit with the commissioner cash, securities, or
2 any combination of cash or securities acceptable to the commissioner in the amount set forth in this
3 section.

4 (2) The amount of the deposit for a health maintenance organization during the first year of its
5 operation ~~must be the greater of:~~

- 6 ~~(a) 5% of its estimated expenditures for health care services for its first year of operation;~~
7 ~~(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~
8 ~~(c) \$100,000 is \$200,000.~~

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

13 (4) Unless not applicable, a health maintenance organization that is in operation on October 1,
14 1987, shall make a deposit equal to the greater of:

- 15 (a) 1% of the preceding 12 months' uncovered expenditures; or
16 (b) ~~\$100,000 on the first day of the fiscal year beginning 6 months or more after October 1, 1987.~~
17 ~~In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its~~
18 ~~estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must~~
19 ~~be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and~~
20 ~~subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual~~
21 ~~uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably~~
22 ~~reflect the preceding year's operating experience and delivery arrangements.~~

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

- 25 (a) the health maintenance organization has sufficient net worth and an adequate history of
26 generating net income to ~~assure~~ ensure its financial viability for the next year;
27 (b) the health maintenance organization's performance and obligations are guaranteed by an
28 organization with sufficient net worth and an adequate history of generating net income; or
29 (c) the health maintenance organization's assets or its contracts with insurers, health service
30 corporations, governments, or other organizations are reasonably sufficient to assure the performance of

1 its obligations.

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

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

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

30 (9) Unless it is operated by an insurer or a health service corporation as a plan, each health

1 maintenance organization ~~shall~~ must have a minimum capital of at least \$200,000 in addition to any deposit
 2 requirements under this section. The capital account must be in excess of any accrued liabilities and be in
 3 the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

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

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

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

8

9 **NEW SECTION. Section 7. Premium increase restriction -- exception.** (1) A health maintenance
 10 organization may not increase a premium for an individual's or an individual's group health care services
 11 agreement more frequently than once during a 12-month period unless failure to increase the premium more
 12 frequently than once during the 12-month period would:

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

14 (b) cause the financial impairment of the health maintenance organization to the extent that further
 15 transaction of insurance by the health maintenance organization would injure or be hazardous to its
 16 enrollees or to the public.

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

19

20 **NEW SECTION. Section 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care
 21 Plan Network Adequacy and Quality Assurance Act".

22

23 **NEW SECTION. Section 9. Purpose.** The purpose and intent of [sections 8 through 29] are to:

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

29 (2) provide for the implementation of state network adequacy and quality assurance standards in
 30 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for

1 detecting and reporting violations of those standards to the commissioner;

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

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

7 (5) provide a streamlined and simplified process by which managed care network adequacy and
8 quality assurance programs may be monitored for compliance THROUGH COORDINATED EFFORTS OF THE
9 COMMISSIONER AND THE DEPARTMENT ~~(AND THE BOARD)~~. It is not the purpose or intent of [sections
10 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care
11 plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance
12 programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

13

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

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

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

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

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

23 (5) "Department" means the department of public health and human services established in
24 2-15-2201.

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

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

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

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

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

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

7 (9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered,
8 or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health
9 care services.

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

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

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

16 (13) "Health carrier" means an entity subject to the insurance laws and rules of this state that
17 contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or
18 reimburse any of the costs of health care services, including a disability insurer, health maintenance
19 organization, or health service corporation or another entity providing a health benefit plan.

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

22 (15) "Managed care plan" means a health benefit plan that either requires or creates incentives,
23 including financial incentives, for a covered person to use health care providers managed, owned, under
24 contract with, or employed by a health carrier, but not preferred provider organizations or other provider
25 networks operated in a fee-for-service indemnity environment.

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

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

1 a managed care plan.

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

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

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

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

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

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

18

19 **NEW SECTION. Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health
20 carriers that offer managed care plans. [Sections 8 through 29] do not exempt a health carrier from the
21 applicable requirements of federal law when providing a managed care plan to medicare recipients or from
22 the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to
23 medicaid recipients.

24

25 **NEW SECTION. Section 12. Department -- general powers and duties -- rulemaking.** (1) The
26 department shall:

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

30 (b) recommend action to the commissioner ~~[OR TO THE BOARD]~~ against a health carrier whose

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

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

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

8

9 **NEW SECTION. Section 13. Network adequacy -- standards -- access plan required.** (1) A health
10 carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and
11 types of providers to ensure that all services to covered persons are accessible without unreasonable delay.
12 Sufficiency in number and type of provider is determined in accordance with the requirements of this
13 section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health
14 carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria
15 may include but are not limited to:

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

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

18 (c) geographic accessibility;

19 (d) waiting times for appointments with participating providers;

20 (e) hours of operation; or

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

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

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

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

3 ~~(5)~~(4) A health carrier offering a managed care plan in this state on October 1, 1998, shall file with
4 the department on October 1, 1998, an access plan complying with subsection ~~(7)~~ (6) and the rules of the
5 department. A health carrier offering a managed care plan in this state for the first time after October 1,
6 1998, shall file with the department an access plan meeting the requirements of subsection ~~(7)~~ (6) and the
7 rules of the department before offering the managed care plan. A plan must be filed with the department
8 in a manner and form complying with the rules of the department. A health carrier shall file any subsequent
9 material changes in its access plan with the department within 30 days of implementation of the change.

10 ~~(6)~~(5) A health carrier may request the department to designate parts of its access plan as
11 proprietary or competitive information, and when designated, that part may not be made public. For the
12 purposes of this section, information is proprietary or competitive if revealing the information would cause
13 the health carrier's competitors to obtain valuable business information. A health carrier shall make the
14 access plans, absent proprietary information, available on its business premises and shall provide a copy
15 of the plan upon request.

16 ~~(7)~~(6) An access plan for each managed care plan offered in this state must describe or contain
17 at least the following:

- 18 (a) a listing of the names and specialties of the health carrier's participating providers;
19 (b) the health carrier's procedures for making referrals within and outside its network;
20 (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of
21 the network to meet the health care needs of populations that enroll in the managed care plan;
22 (d) the health carrier's efforts to address the needs of covered persons with limited English
23 proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental
24 disabilities;
25 (e) the health carrier's methods for assessing the health care needs of covered persons and their
26 satisfaction with services;
27 (f) the health carrier's method of informing covered persons of the plan's services and features,
28 including but not limited to the plan's grievance procedures, its process for choosing and changing
29 providers, and its procedures for providing and approving emergency and specialty care;
30 (g) the health carrier's system for ensuring the coordination and continuity of care for covered

1 persons referred to specialty physicians and for covered persons using ancillary services, including social
 2 services and other community resources, and for ensuring appropriate discharge planning;

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

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

9 (j) any other information required by the department to determine compliance with [sections 13
 10 through 21] and the rules implementing [sections 13 through 21].

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

13
 14 NEW SECTION. Section 14. Provider responsibility for care -- contracts -- prohibited collection
 15 practices. (1) A health carrier offering a managed care plan shall establish a mechanism, described in detail
 16 in the contract, by which a participating provider will be notified on an ongoing basis of the covered health
 17 care services for which the participating provider is responsible, including any limitations or conditions on
 18 those health care services.

19 ~~(2)~~(1) A contract between a health carrier and a participating provider must set forth a hold
 20 harmless provision specifying protection for covered persons. This requirement is met by including in a
 21 contract a provision substantially the same as the following:

22 "The provider agrees that the provider may not for any reason, including but not limited to
 23 nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach
 24 of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or
 25 have any recourse from or against a covered person or a person other than the health carrier or intermediary
 26 acting on behalf of the covered person for services provided pursuant to this agreement. This agreement
 27 does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically
 28 provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis
 29 to a covered person. This agreement does not prohibit a provider, except a health care professional who
 30 is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to

1 that health carrier's covered persons and no others, and a covered person from agreeing to continue
 2 services solely at the expense of the covered person if the provider has clearly informed the covered person
 3 that the health carrier may not cover or continue to cover a specific service or services. Except as provided
 4 in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available
 5 for obtaining payment for services from the health carrier."

6 ~~(3)(2)~~ A contract between a health carrier and a participating provider must state that if a health
 7 carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered
 8 persons will continue through the end of the period for which a premium has been paid to the health carrier
 9 on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from
 10 an ACUTE CARE inpatient facility, whichever occurs last. Covered benefits to a covered person confined
 11 in an ACUTE CARE inpatient facility on the date of insolvency or other cessation of operations must be
 12 continued by a provider until the confinement in an inpatient facility is no longer medically necessary.

13 ~~(4)(3)~~ The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2)
 14 must be construed in favor of the covered person, survive the termination of the contract regardless of the
 15 reason for termination, including the insolvency of the health carrier, and supersede an oral or written
 16 contrary agreement between a participating provider and a covered person or the representative of a
 17 covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered
 18 benefits provisions required by subsections ~~(2) and (3)~~ (1) AND (2).

19 ~~(5)(4)~~ A participating provider may not collect or attempt to collect from a covered person money
 20 owed to the provider by the health carrier.

21

22 **NEW SECTION. Section 15. Selection of providers -- professional credentials standards.** (1) A
 23 health carrier shall adopt standards for selecting participating providers who are primary care professionals
 24 and for each health care professional specialty within the health carrier's network. The health carrier shall
 25 use the standards to select health care professionals, the health carrier's intermediaries, and any provider
 26 network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow
 27 the health carrier to:

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

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

3 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails
4 to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 13
5 through 21] and the rules implementing [sections 13 through 21].

6 (3) [Sections 13 through 21] do not require a health carrier, its intermediary, or a provider network
7 with which the health carrier or its intermediary contract to employ specific providers or types of providers
8 who may meet their selection criteria or to contract with or retain more providers or types of providers than
9 are necessary to maintain an adequate network.

10 (4) A health carrier may use criteria established in accordance with the provisions of this section
11 to select health care professionals allowed to participate in the health carrier's managed care plan. A health
12 carrier shall make its selection standards for participating providers available for review by the department
13 and by each health care professional who is subject to the selection standards.

14
15 **NEW SECTION. Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering
16 a managed care plan shall notify, in writing, prospective participating providers of the participating
17 providers' responsibilities concerning the health carrier's administrative policies and programs, including but
18 not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance
19 procedures, data reporting requirements, confidentiality requirements, and applicable federal or state
20 requirements.

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

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

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

30 (5) A health carrier and participating provider shall provide at least 60 days' written notice to each

1 other before terminating the contract between them without cause. The health carrier shall make a good
2 faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a
3 notice of termination from or to a participating provider, to all covered persons who are patients seen on
4 a regular basis by the participating provider whose contract is terminating, irrespective of whether the
5 termination is for cause or without cause. If a contract termination involves a primary care professional,
6 all covered persons who are patients of that primary care professional must be notified.

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

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

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

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

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

24 (11) A contract between a health carrier and a participating provider may not contain definitions
25 or other provisions that conflict with the definitions or provisions contained in the managed care plan or
26 [sections 8 through 29].

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

1 **NEW SECTION. Section 17. Emergency services.** (1) A health carrier offering a managed care plan
2 shall provide or pay for emergency services screening and emergency services and may not require prior
3 authorization for either of those services. If an emergency services screening determines that emergency
4 services or emergency services of a particular type are unnecessary for a covered person, emergency
5 services or emergency services of the type determined unnecessary by the screening need not be covered
6 by the health carrier unless otherwise covered under the health benefit plan. However, if screening
7 determines that emergency services or emergency services of a particular type are necessary, those
8 services must be covered by the health carrier. A health carrier shall cover emergency services if the health
9 carrier, acting through a participating provider or other authorized representative, has authorized the
10 provision of emergency services.

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

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

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

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

25

26 **NEW SECTION. Section 18. Use of intermediaries -- responsibilities of health carriers,**
27 **intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions
28 of [sections 8 through 29], and contracting with an intermediary for all or some of the services for which
29 a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

30 (2) A health carrier may determine whether a subcontracted provider participates in the provider's

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

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

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

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

15 (6) An intermediary shall allow the COMMISSIONER AND THE department access to the
16 intermediary's books, records, claim information, billing information, and other documentation of services
17 provided to covered persons that are required by any of those entities to determine compliance with
18 [sections 13 through 21] and the rules implementing [sections 13 through 21].

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

22

23 **NEW SECTION. Section 19. Contract filing requirements -- material changes -- state access to**
24 **contracts.** (1) On October 1, 1998, a health carrier offering a managed care plan shall file with the
25 department sample contract forms proposed for use with its participating providers and intermediaries.

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

30 (3) A health carrier shall maintain participating provider and intermediary contracts at its principal

1 place of business in this state, or the health carrier must have access to all contracts and provide copies
2 to the department upon 20 days' prior written notice from the department.

3

4 **NEW SECTION. Section 20. General contracting requirements.** (1) The execution of a contract
5 for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty
6 to provide health care services to a person with whom the health carrier has contracted and does not
7 relieve the health carrier of its responsibility for compliance with [sections 8 through 29] or the rules
8 implementing [sections 8 through 29].

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

11

12 **NEW SECTION. Section 21. Contract compliance dates.** (1) A contract between a health carrier
13 and a participating provider or intermediary in effect on October 1, 1997, must comply with [sections 13
14 through 21] and the rules implementing [sections 13 through 21] by April 1, 1999. The department may
15 extend the April 1 date for an additional period of up to 6 months if the health carrier demonstrates good
16 cause for an extension.

17 (2) A contract between a health carrier and a participating provider or intermediary issued or put
18 into effect on or after April 1, 1998, must comply with [sections 13 through 21] and the rules implementing
19 [sections 13 through 21] on the day that it is issued or put into effect.

20 (3) A contract between a health carrier and a participating provider or intermediary not described
21 in subsection (1) or (2) must comply with [sections 13 through 21] and the rules implementing [sections
22 13 through 21] by April 1, 1999.

23

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

26

27 **NEW SECTION. Section 23. Quality assurance -- national accreditation.** (1) A health carrier
28 whose managed care plan has been accredited by a nationally recognized accrediting organization shall
29 annually provide a copy of the accreditation and the accrediting standards used by the accrediting
30 organization to the department.

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

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

6 (4) [Section 24] does not apply to a health carrier's managed care plan if the health carrier
7 maintains current accreditation by a nationally recognized accrediting organization whose standards meet
8 or exceed state quality assurance standards adopted pursuant to [sections 23 through 27].

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

11
12 **NEW SECTION. Section 24. Standards for health carrier quality assessment programs.** A health
13 carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure
14 systems sufficient to accurately measure the quality of health care services provided to covered persons
15 on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this
16 requirement, a health carrier shall:

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

20 (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory
21 agencies, providers, and consumers as provided in [section 26];

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

25 (4) file a written description of the quality assessment program and any subsequent material
26 changes with the department in a format that must be prescribed by rules of the department. The
27 description must include a signed certification by a corporate officer of the health carrier that the health
28 carrier's quality assessment program meets the requirements of [sections 23 through 27].

29
30 **NEW SECTION. Section 25. Standards for health carrier quality improvement programs.** A health

1 carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 24],
2 adopt and use systems and methods necessary to improve the quality of health care provided in the health
3 carrier's managed care plan as indicated by the health carrier's quality assessment program and as required
4 by this section. To comply with this requirement, a health carrier subject to this section shall:

5 (1) establish an internal system capable of identifying opportunities to improve care;

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

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

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

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

18

19 **NEW SECTION. Section 26. Reporting and disclosure requirements.** (1) A health carrier offering
20 a closed plan or a combination plan shall document and communicate information, as required in this
21 section, about its quality assurance program. The health carrier shall:

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

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

26 (c) make available annually to providers and covered persons a report containing findings from its
27 quality assurance program and information about its progress in meeting internal goals and external
28 standards, when available.

29 (2) A health carrier shall certify to the department annually that its quality assurance program and
30 the materials provided to providers and consumers in accordance with subsection (1) meet the requirements

1 of [sections 23 through 27].

2 (3) A health carrier shall make available, upon request and payment of a reasonable fee, the
3 materials certified pursuant to subsection (2), except for the materials subject to the confidentiality
4 requirements of [section 27] and materials that are proprietary to the managed care plan. A health carrier
5 shall retain all certified materials for at least 3 years from the date that the material was certified or until
6 the material has been examined as part of a market conduct examination, whichever is later.

7
8 **NEW SECTION. Section 27. Confidentiality of health care and quality assurance records --**
9 **disclosure.** (1) Except as provided in subsection (2), the following information held by a health carrier
10 offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a
11 person:

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

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

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

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

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

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

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

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

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

30 (b) the covered person may also be disclosed upon a written, dated, and signed approval of the

1 covered person or of the parent or guardian of a covered person if the covered person is a minor and if the
2 information does not identify the provider;

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

5
6 **NEW SECTION. Section 28. Enforcement.** (1) If the department ~~[OR THE BOARD]~~ determines that
7 a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through
8 29], the department ~~[OR THE BOARD]~~ may recommend corrective action to the health carrier.

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

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

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

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

18 (d) the commissioner determines that a health carrier has violated or is violating [sections 8 through
19 29] or the rules implementing [sections 8 through 29].

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

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

24 (b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part
25 3.

26
27 **NEW SECTION. Section 29. Jurisdiction over contract actions.** The district courts have jurisdiction
28 over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].

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

1 ~~FOLLOWING DEFINITIONS APPLY:~~

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

4 ~~(2) "CLOSED PLAN" MEANS A MANAGED CARE PLAN THAT REQUIRES COVERED PERSONS TO~~
 5 ~~USE ONLY PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.~~

6 ~~(3) "COMBINATION PLAN" MEANS AN OPEN PLAN WITH A CLOSED COMPONENT.~~

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

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

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

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

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

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

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

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

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

27 ~~(10) "HEALTH BENEFIT PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT~~
 28 ~~ENTERED INTO, OFFERED, OR ISSUED BY A HEALTH CARRIER TO PROVIDE, DELIVER, ARRANGE FOR,~~
 29 ~~PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.~~

30 ~~(11) "HEALTH CARE PROFESSIONAL" MEANS A PHYSICIAN OR OTHER HEALTH CARE~~

~~1 PRACTITIONER LICENSED, ACCREDITED, OR CERTIFIED PURSUANT TO THE LAWS OF THIS STATE TO
2 PERFORM SPECIFIED HEALTH CARE SERVICES CONSISTENT WITH STATE LAW.~~

~~3 (12) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL OR
4 A FACILITY.~~

~~5 (13) "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION,
6 TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE.~~

~~7 (14) "HEALTH CARRIER" MEANS AN ENTITY SUBJECT TO THE INSURANCE LAWS AND RULES
8 OF THIS STATE THAT CONTRACTS, OFFERS TO CONTRACT, OR ENTERS INTO AN AGREEMENT TO
9 PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE
10 SERVICES, INCLUDING A DISABILITY INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH
11 SERVICE CORPORATION OR ANOTHER ENTITY PROVIDING A HEALTH BENEFIT PLAN.~~

~~12 (15) "INTERMEDIARY" MEANS A PERSON AUTHORIZED TO NEGOTIATE, EXECUTE, AND BE A
13 PARTY TO A CONTRACT BETWEEN A HEALTH CARRIER AND A PROVIDER OR BETWEEN A HEALTH
14 CARRIER AND A NETWORK.~~

~~15 (16) "MANAGED CARE PLAN" MEANS A HEALTH BENEFIT PLAN THAT EITHER REQUIRES OR
16 CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR A COVERED PERSON TO USE HEALTH
17 CARE PROVIDERS MANAGED, OWNED, UNDER CONTRACT WITH, OR EMPLOYED BY A HEALTH
18 CARRIER, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS
19 OPERATED IN A FEE FOR SERVICE INDEMNITY ENVIRONMENT.~~

~~20 (17) "MEDICALLY NECESSARY" MEANS SERVICES OR SUPPLIES THAT ARE NECESSARY AND
21 APPROPRIATE FOR THE TREATMENT OF A COVERED PERSON'S EMERGENCY MEDICAL CONDITION OR
22 FOR THE PREVENTIVE CARE OF A COVERED PERSON ACCORDING TO ACCEPTED STANDARDS OF
23 MEDICAL PRACTICE.~~

~~24 (18) "NETWORK" MEANS THE GROUP OF PARTICIPATING PROVIDERS THAT PROVIDES HEALTH
25 CARE SERVICES TO A MANAGED CARE PLAN.~~

~~26 (19) "OPEN PLAN" MEANS A MANAGED CARE PLAN OTHER THAN A CLOSED PLAN THAT
27 PROVIDES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR COVERED PERSONS TO USE
28 PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.~~

~~29 (20) "PARTICIPATING PROVIDER" MEANS A PROVIDER WHO, UNDER A CONTRACT WITH A
30 HEALTH CARRIER OR WITH THE HEALTH CARRIER'S CONTRACTOR, SUBCONTRACTOR, OR~~

1 ~~INTERMEDIARY, HAS AGREED TO PROVIDE HEALTH CARE SERVICES TO COVERED PERSONS WITH AN~~
 2 ~~EXPECTATION OF RECEIVING PAYMENT, OTHER THAN COINSURANCE, COPAYMENTS, OR~~
 3 ~~DEDUCTIBLES, DIRECTLY OR INDIRECTLY FROM THE HEALTH CARRIER.~~

4 ~~(21) "PRIMARY CARE PROFESSIONAL" MEANS A PARTICIPATING HEALTH CARE PROFESSIONAL~~
 5 ~~DESIGNATED BY THE HEALTH CARRIER TO SUPERVISE, COORDINATE, OR PROVIDE INITIAL CARE OR~~
 6 ~~CONTINUING CARE TO A COVERED PERSON AND WHO MAY BE REQUIRED BY THE HEALTH CARRIER~~
 7 ~~TO INITIATE A REFERRAL FOR SPECIALTY CARE AND TO MAINTAIN SUPERVISION OF HEALTH CARE~~
 8 ~~SERVICES RENDERED TO THE COVERED PERSON.~~

9 ~~(22) "QUALITY ASSESSMENT" MEANS THE MEASUREMENT AND EVALUATION OF THE QUALITY~~
 10 ~~AND OUTCOMES OF MEDICAL CARE PROVIDED TO INDIVIDUALS, GROUPS, OR POPULATIONS.~~

11 ~~(23) "QUALITY ASSURANCE" MEANS QUALITY ASSESSMENT AND QUALITY IMPROVEMENT.~~

12 ~~(24) "QUALITY IMPROVEMENT" MEANS AN EFFORT TO IMPROVE THE PROCESSES AND~~
 13 ~~OUTCOMES RELATED TO THE PROVISION OF HEALTH CARE SERVICES WITHIN A HEALTH PLAN.~~

14
 15 ~~NEW SECTION. SECTION 31. BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE.~~

16 ~~(1) THERE IS A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE. THE BOARD IS~~
 17 ~~COMPOSED OF A MEDICAL DIRECTOR, THE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND~~
 18 ~~HUMAN SERVICES, PROVIDED FOR IN 2-15-2201, AND THE COMMISSIONER OF INSURANCE, PROVIDED~~
 19 ~~FOR IN 2-15-1903.~~

20 ~~(2) THE MEDICAL DIRECTOR IS APPOINTED BY THE GOVERNOR AND MUST BE LICENSED AS~~
 21 ~~A PHYSICIAN BY THE STATE OF MONTANA. THE MEDICAL DIRECTOR MUST BE A SPECIALIST IN~~
 22 ~~EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL~~
 23 ~~DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.~~

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

25 ~~(4) THE BOARD IS ATTACHED FOR ADMINISTRATIVE PURPOSES TO THE DEPARTMENT~~
 26 ~~PURSUANT TO 2-16-121.~~

27
 28 ~~NEW SECTION. SECTION 32. BOARD -- GENERAL POWERS AND DUTIES. THE BOARD SHALL:~~

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

1 ~~THROUGH 29];~~

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

4 ~~(3) RECOMMEND ACTION TO THE COMMISSIONER AGAINST A HEALTH CARRIER WHOSE~~
5 ~~MANAGED CARE PLAN DOES NOT COMPLY WITH STANDARDS FOR NETWORK ADEQUACY AND~~
6 ~~QUALITY ASSURANCE ADOPTED BY THE BOARD.~~

7

8 **NEW SECTION. Section 30. Codification instruction.** (1) [Section 7] is intended to be codified as
9 an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 7].

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

12

13 **NEW SECTION. Section 31. Severability.** If a part of [this act] is invalid, all valid parts that are
14 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its
15 applications, the part remains in effect in all valid applications that are severable from the invalid
16 applications.

17

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

21

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

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

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

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

29

30 ~~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.

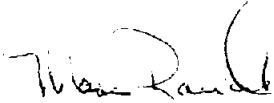
Senate Bill 365 establishes adequate health care networks and quality of managed care. It is an important and visionary bill that will benefit both consumers and managed health care providers in Montana. Applications for health maintenance organizations are pending, and the bill needs to be passed this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

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

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,

A handwritten signature in black ink, appearing to read "Marc Racicot", written in a cursive style.

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"

1 SENATE BILL NO. 365

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

7
 8 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR THE REGULATION OF HEALTH INSURANCE
 9 CARRIERS WHO OFFER MANAGED CARE PLANS; PROVIDING FOR STATE NETWORK ADEQUACY AND
 10 QUALITY ASSURANCE STANDARDS AND A MEANS FOR ENFORCING THE STANDARDS; REGULATING
 11 CONTRACTS RELATING TO MANAGED CARE PLANS; PROVIDING REPORTING AND DISCLOSURE
 12 REQUIREMENTS; PROVIDING FOR CONFIDENTIALITY OF HEALTH CARE INFORMATION; PROVIDING
 13 DEFINITIONS; APPLYING PREMIUM INCREASE RESTRICTIONS TO HEALTH MAINTENANCE
 14 ORGANIZATIONS; REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO FILE FINANCIAL
 15 STATEMENTS; REQUIRING PROTECTION AGAINST INSOLVENCY BY HEALTH MAINTENANCE
 16 ORGANIZATIONS; ~~CREATING A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE~~
 17 ~~EFFECTIVE JULY 1, 2001; PROVIDING FOR POWERS AND DUTIES OF THE BOARD;~~ AMENDING
 18 SECTIONS 33-22-1703, 33-22-1707, 33-31-102, 33-31-111, 33-31-211, AND 33-31-216, MCA; AND
 19 PROVIDING EFFECTIVE DATES, ~~AND~~ AND AN APPLICABILITY DATE, AND A TERMINATION DATE."

20
21 STATEMENT OF INTENT

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

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

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

1 In order to promote uniformity of standards applicable to all managed care plans, state quality
 2 assurance standards for small managed care plans must consist of standards that are ~~at least the equivalent~~
 3 ~~of health plan employer data and information standards. Any other standards adopted must be~~ appropriate
 4 for quality assurance in Montana.

5 The department ~~AND SUBSEQUENTLY THE BOARD OF NETWORK ADEQUACY AND QUALITY~~
 6 ~~ASSURANCE~~ may refer reports of noncompliance by a health carrier to the commissioner for corrective
 7 action. Under the department's rulemaking authority, the department shall specify network adequacy and
 8 quality assurance review processes.

9 [Section 19] designates the department of public health and human services as the place for
 10 insurance carriers to file documents related to managed care provider network adequacy and quality
 11 assurance. The department shall adopt rules establishing procedures for filing these documents and shall
 12 adopt rules specifying processes for amending or withdrawing documents already filed that relate to
 13 network adequacy and quality assurance.

14
 15 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

16
 17 **Section 1.** Section 33-22-1703, MCA, is amended to read:

18 **"33-22-1703. Definitions.** As used in this part, the following definitions apply:

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

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

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

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

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

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

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

1 ~~(c) a bodily organ or part would be seriously damaged.~~ health care items or services furnished or
 2 required to evaluate and treat an emergency medical condition.

3 ~~(2)(3)~~ "Health benefit plan" means the health insurance policy or subscriber arrangement between
 4 the insured or subscriber and the health care insurer that defines the covered services and benefit levels
 5 available.

6 ~~(3)(4)~~ "Health care insurer" means:

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

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

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

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

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

13 ~~(4)(5)~~ "Health care services" means health care services or products rendered or sold by a provider
 14 within the scope of the provider's license or legal authorization or services provided under Title 33, chapter
 15 22, part 7.

16 ~~(5)(6)~~ "Insured" means an individual entitled to reimbursement for expenses of health care services
 17 under a policy or subscriber contract issued or administered by an insurer.

18 ~~(6)(7)~~ "Preferred provider" means a provider or group of providers who have contracted to provide
 19 specified health care services.

20 ~~(7)(8)~~ "Preferred provider agreement" means a contract between or on behalf of a health care
 21 insurer and a preferred provider.

22 ~~(8)(9)~~ "Provider" means an individual or entity licensed or legally authorized to provide health care
 23 services or services covered within Title 33, chapter 22, part 7.

24 ~~(9)(10)~~ "Subscriber" means a certificate holder or other person on whose behalf the health care
 25 insurer is providing or paying for health care coverage."

26

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

28 **"33-22-1707. Rules.** The commissioner ~~shall promulgate~~ may adopt rules necessary to implement
 29 the provisions of this part."
 30

1 **Section 3.** Section 33-31-102, MCA, is amended to read:

2 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the
3 following definitions apply:

4 (1) "Basic health care services" means:

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

6 (b) inpatient hospital and provider care;

7 (c) outpatient medical services;

8 (d) medical treatment and referral services;

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

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

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

13 (h) preventive health services, including:

14 (i) immunizations;

15 (ii) well-child care from birth;

16 (iii) periodic health evaluations for adults;

17 (iv) voluntary family planning services;

18 (v) infertility services; and

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

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

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

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

26 (3) "Enrollee" means a person:

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

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

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

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

3 (5) "Health care services" means:

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

5 (b) the services included in hospitalizing a person;

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

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

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

11 (7) "Health maintenance organization" means a person who provides or arranges for basic health
12 care services to enrollees on a prepaid ~~or other financial~~ basis, either directly through provider employees
13 or through contractual or other arrangements with a provider or a group of providers. This subsection does
14 not limit methods of provider payments made by health maintenance organizations. THIS TERM APPLIES
15 TO PROVIDER SPONSORED ORGANIZATIONS THAT DIRECTLY ASSUME RISK OR PROVIDE SERVICES
16 DIRECTLY TO CUSTOMERS THROUGH CONTRACTS WITH EMPLOYERS OR PURCHASING
17 COOPERATIVES.

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

21 (9) "Person" means:

22 (a) an individual;

23 (b) a group of individuals;

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

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

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

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

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

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

6 ~~(12) "PROVIDER SPONSORED ORGANIZATION" MEANS AN ORGANIZATION OF PHYSICIANS,~~
 7 ~~HOSPITALS, AND OTHER PROVIDERS THAT ARE ORGANIZED FOR THE PURPOSE OF SECURING~~
 8 ~~CONTRACTS WITH PAYERS TO PROVIDE HEALTH CARE SERVICES. THE TERM INCLUDES A~~
 9 ~~PHYSICIAN HOSPITAL ORGANIZATION, A PHYSICIAN SPONSORED NETWORK, A PHYSICIAN GROUP~~
 10 ~~PRACTICE, AND A HOSPITAL PHYSICIAN ORGANIZATION.~~

11 ~~(12)(13)(12)~~ "Uncovered expenditures" mean the costs of health care services that are covered by
 12 a health maintenance organization and for which an enrollee is liable if the health maintenance organization
 13 becomes insolvent."
 14

15 **Section 4.** Section 33-31-111, MCA, is amended to read:

16 **"33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise
 17 provided in this chapter, the insurance or health service corporation laws do not apply to any health
 18 maintenance organization authorized to transact business under this chapter. This provision does not apply
 19 to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
 20 corporation laws of this state except with respect to its health maintenance organization activities
 21 authorized and regulated pursuant to this chapter.

22 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority
 23 or its representatives ~~may not be construed as~~ is not a violation of any law relating to solicitation or
 24 advertising by health professionals.

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

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

29 (5) ~~The provisions of this~~ This section ~~do~~ does not exempt a health maintenance organization from
 30 material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance

1 organization must be considered an insurer for the purposes of 33-3-701 through 33-3-704.

2 (6) This section does not exempt a health maintenance organization from network adequacy and
3 quality assurance requirements provided under [sections 8 through 29]."

4

5 **Section 5.** Section 33-31-211, MCA, is amended to read:

6 **"33-31-211. Annual ~~statement~~ statements -- revocation for failure to file -- penalty for false**
7 **swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized
8 health maintenance organization shall annually on or before March 1 file with the commissioner a full and
9 true statement of its financial condition, transactions, and affairs as of the preceding December 31. The
10 statement must be in the general form and content required by the commissioner. The statement must be
11 verified by the oath of at least two principal officers of the health maintenance organization. The
12 commissioner may ~~in his discretion~~ waive any verification under oath. In addition, a health maintenance
13 organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file
14 on or before June 1 an audited financial statement.

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

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

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

28

29 **Section 6.** Section 33-31-216, MCA, is amended to read:

30 **"33-31-216. Protection against insolvency.** (1) Except as provided in subsections (4) through (7),

1 each authorized health maintenance organization shall deposit with the commissioner cash, securities, or
 2 any combination of cash or securities acceptable to the commissioner in the amount set forth in this
 3 section.

4 (2) The amount of the deposit for a health maintenance organization during the first year of its
 5 operation ~~must be the greater of:~~

- 6 ~~(a) 5% of its estimated expenditures for health care services for its first year of operation;~~
 7 ~~(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~
 8 ~~(c) \$100,000 is \$200,000.~~

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

13 (4) Unless not applicable, a health maintenance organization that is in operation on October 1,
 14 1987, shall make a deposit equal to the greater of:

- 15 (a) 1% of the preceding 12 months' uncovered expenditures; or
 16 (b) ~~\$100,000 on the first day of the fiscal year beginning 6 months or more after October 1, 1987.~~
 17 ~~In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its~~
 18 ~~estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must~~
 19 ~~be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and~~
 20 ~~subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual~~
 21 ~~uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably~~
 22 ~~reflect the preceding year's operating experience and delivery arrangements.~~

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

- 25 (a) the health maintenance organization has sufficient net worth and an adequate history of
 26 generating net income to ~~assure~~ ensure its financial viability for the next year;
 27 (b) the health maintenance organization's performance and obligations are guaranteed by an
 28 organization with sufficient net worth and an adequate history of generating net income; or
 29 (c) the health maintenance organization's assets or its contracts with insurers, health service
 30 corporations, governments, or other organizations are reasonably sufficient to assure the performance of

1 its obligations.

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

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

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

30 (9) Unless it is operated by an insurer or a health service corporation as a plan, each health

1 maintenance organization ~~shall~~ must have a minimum capital of at least \$200,000 in addition to any deposit
 2 requirements under this section. The capital account must be in excess of any accrued liabilities and be in
 3 the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

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

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

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

8
 9 **NEW SECTION. Section 7. Premium increase restriction -- exception.** (1) A health maintenance
 10 organization may not increase a premium for an individual's or an individual's group health care services
 11 agreement more frequently than once during a 12-month period unless failure to increase the premium more
 12 frequently than once during the 12-month period would:

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

14 (b) cause the financial impairment of the health maintenance organization to the extent that further
 15 transaction of insurance by the health maintenance organization would injure or be hazardous to its
 16 enrollees or to the public.

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

19
 20 **NEW SECTION. Section 8. Short title.** [Sections 8 through 29] may be cited as the "Managed Care
 21 Plan Network Adequacy and Quality Assurance Act".

22
 23 **NEW SECTION. Section 9. Purpose.** The purpose and intent of [sections 8 through 29] are to:

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

29 (2) provide for the implementation of state network adequacy and quality assurance standards in
 30 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for

1 detecting and reporting violations of those standards to the commissioner;

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

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

7 (5) provide a streamlined and simplified process by which managed care network adequacy and
8 quality assurance programs may be monitored for compliance THROUGH COORDINATED EFFORTS OF THE
9 COMMISSIONER AND THE DEPARTMENT ~~(AND THE BOARD)~~. It is not the purpose or intent of [sections
10 8 through 29] to apply quality assurance standards applicable to medicaid or medicare to managed care
11 plans regulated pursuant to [sections 8 through 29] or to create or require the creation of quality assurance
12 programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

13

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

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

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

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

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

23 (5) "Department" means the department of public health and human services established in
24 2-15-2201.

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

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

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

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

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

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

7 (9) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered,
8 or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health
9 care services.

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

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

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

16 (13) "Health carrier" means an entity subject to the insurance laws and rules of this state that
17 contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or
18 reimburse any of the costs of health care services, including a disability insurer, health maintenance
19 organization, or health service corporation or another entity providing a health benefit plan.

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

22 (15) "Managed care plan" means a health benefit plan that either requires or creates incentives,
23 including financial incentives, for a covered person to use health care providers managed, owned, under
24 contract with, or employed by a health carrier, but not preferred provider organizations or other provider
25 networks operated in a fee-for-service indemnity environment.

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

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

1 a managed care plan.

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

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

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

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

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

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

18
19 **NEW SECTION. Section 11. Applicability and scope.** [Sections 8 through 29] apply to all health
20 carriers that offer managed care plans. [Sections 8 through 29] do not exempt a health carrier from the
21 applicable requirements of federal law when providing a managed care plan to medicare recipients or from
22 the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to
23 medicaid recipients.

24
25 **NEW SECTION. Section 12. Department -- general powers and duties -- rulemaking.** (1) The
26 department shall:

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

30 (b) recommend action to the commissioner ~~[OR TO THE BOARD]~~ against a health carrier whose

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

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

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

8

9 **NEW SECTION. Section 13. Network adequacy -- standards -- access plan required.** (1) A health
10 carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and
11 types of providers to ensure that all services to covered persons are accessible without unreasonable delay.
12 Sufficiency in number and type of provider is determined in accordance with the requirements of this
13 section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health
14 carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria
15 may include but are not limited to:

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

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

18 (c) geographic accessibility;

19 (d) waiting times for appointments with participating providers;

20 (e) hours of operation; or

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

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

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

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

3 ~~(5)~~(4) A health carrier offering a managed care plan in this state on October 1, ~~1998~~ 1999, shall
4 file with the department on October 1, ~~1998~~ 1999, an access plan complying with subsection ~~(7)~~ (6) and
5 the rules of the department. A health carrier offering a managed care plan in this state for the first time
6 after October 1, ~~1998~~ 1999, shall file with the department an access plan meeting the requirements of
7 subsection ~~(7)~~ (6) and the rules of the department before offering the managed care plan. A plan must be
8 filed with the department in a manner and form complying with the rules of the department. A health
9 carrier shall file any subsequent material changes in its access plan with the department within 30 days of
10 implementation of the change.

11 ~~(6)~~(5) A health carrier may request the department to designate parts of its access plan as
12 proprietary or competitive information, and when designated, that part may not be made public. For the
13 purposes of this section, information is proprietary or competitive if revealing the information would cause
14 the health carrier's competitors to obtain valuable business information. A health carrier shall make the
15 access plans, absent proprietary information, available on its business premises and shall provide a copy
16 of the plan upon request.

17 ~~(7)~~(6) An access plan for each managed care plan offered in this state must describe or contain
18 at least the following:

- 19 (a) a listing of the names and specialties of the health carrier's participating providers;
- 20 (b) the health carrier's procedures for making referrals within and outside its network;
- 21 (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of
22 the network to meet the health care needs of populations that enroll in the managed care plan;
- 23 (d) the health carrier's efforts to address the needs of covered persons with limited English
24 proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental
25 disabilities;
- 26 (e) the health carrier's methods for assessing the health care needs of covered persons and their
27 satisfaction with services;
- 28 (f) the health carrier's method of informing covered persons of the plan's services and features,
29 including but not limited to the plan's grievance procedures, its process for choosing and changing
30 providers, and its procedures for providing and approving emergency and specialty care;

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

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

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

10 (j) any other information required by the department to determine compliance with [sections 13
 11 through 21] and the rules implementing [sections 13 through 21].

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

14
 15 NEW SECTION. Section 14. Provider responsibility for care -- contracts -- prohibited collection
 16 practices. (1) A health carrier offering a managed care plan shall establish a mechanism, described in detail
 17 in the contract, by which a participating provider will be notified on an ongoing basis of the covered health
 18 care services for which the participating provider is responsible, including any limitations or conditions on
 19 those health care services.

20 ~~(2)~~(1) A contract between a health carrier and a participating provider must set forth a hold
 21 harmless provision specifying protection for covered persons. This requirement is met by including in a
 22 contract a provision substantially the same as the following:

23 "The provider agrees that the provider may not for any reason, including but not limited to
 24 nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach
 25 of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or
 26 have any recourse from or against a covered person or a person other than the health carrier or intermediary
 27 acting on behalf of the covered person for services provided pursuant to this agreement. This agreement
 28 does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically
 29 provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis
 30 to a covered person. This agreement does not prohibit a provider, except a health care professional who

1 is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to
 2 that health carrier's covered persons and no others, and a covered person from agreeing to continue
 3 services solely at the expense of the covered person if the provider has clearly informed the covered person
 4 that the health carrier may not cover or continue to cover a specific service or services. Except as provided
 5 in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available
 6 for obtaining payment for services from the health carrier."

7 ~~(3)~~(2) A contract between a health carrier and a participating provider must state that if a health
 8 carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered
 9 persons will continue through the end of the period for which a premium has been paid to the health carrier
 10 on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from
 11 an ACUTE CARE inpatient facility, whichever occurs last. Covered benefits to a covered person confined
 12 in an ACUTE CARE inpatient facility on the date of insolvency or other cessation of operations must be
 13 continued by a provider until the confinement in an inpatient facility is no longer medically necessary.

14 ~~(4)~~(3) The contract provisions that satisfy the requirements of subsections ~~(2) and (3)~~ (1) AND (2)
 15 must be construed in favor of the covered person, survive the termination of the contract regardless of the
 16 reason for termination, including the insolvency of the health carrier, and supersede an oral or written
 17 contrary agreement between a participating provider and a covered person or the representative of a
 18 covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered
 19 benefits provisions required by subsections ~~(2) and (3)~~ (1) AND (2).

20 ~~(5)~~(4) A participating provider may not collect or attempt to collect from a covered person money
 21 owed to the provider by the health carrier.

22

23 NEW SECTION. Section 15. Selection of providers -- professional credentials standards. (1) A
 24 health carrier shall adopt standards for selecting participating providers who are primary care professionals
 25 and for each health care professional specialty within the health carrier's network. The health carrier shall
 26 use the standards to select health care professionals, the health carrier's intermediaries, and any provider
 27 network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow
 28 the health carrier to:

29 (a) avoid high-risk populations by excluding a provider because the provider is located in a
 30 geographic area that contains populations or providers presenting a risk of higher than average claims,

1 losses, or use of health care services; or

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

4 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails
5 to meet the other legitimate selection criteria of the health carrier adopted in compliance with [sections 13
6 through 21] and the rules implementing [sections 13 through 21].

7 (3) [Sections 13 through 21] do not require a health carrier, its intermediary, or a provider network
8 with which the health carrier or its intermediary contract to employ specific providers or types of providers
9 who may meet their selection criteria or to contract with or retain more providers or types of providers than
10 are necessary to maintain an adequate network.

11 (4) A health carrier may use criteria established in accordance with the provisions of this section
12 to select health care professionals allowed to participate in the health carrier's managed care plan. A health
13 carrier shall make its selection standards for participating providers available for review by the department
14 and by each health care professional who is subject to the selection standards.

15

16 **NEW SECTION. Section 16. Health carriers -- general responsibilities.** (1) A health carrier offering
17 a managed care plan shall notify, in writing, prospective participating providers of the participating
18 providers' responsibilities concerning the health carrier's administrative policies and programs, including but
19 not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance
20 procedures, data reporting requirements, confidentiality requirements, and applicable federal or state
21 requirements.

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

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

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

1 (5) A health carrier and participating provider shall provide at least 60 days' written notice to each
2 other before terminating the contract between them without cause. The health carrier shall make a good
3 faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a
4 notice of termination from or to a participating provider, to all covered persons who are patients seen on
5 a regular basis by the participating provider whose contract is terminating, irrespective of whether the
6 termination is for cause or without cause. If a contract termination involves a primary care professional,
7 all covered persons who are patients of that primary care professional must be notified.

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

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

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

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

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

25 (11) A contract between a health carrier and a participating provider may not contain definitions
26 or other provisions that conflict with the definitions or provisions contained in the managed care plan or
27 [sections 8 through 29].

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

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

2

3 **NEW SECTION. Section 17. Emergency services.** (1) A health carrier offering a managed care plan
4 shall provide or pay for emergency services screening and emergency services and may not require prior
5 authorization for either of those services. If an emergency services screening determines that emergency
6 services or emergency services of a particular type are unnecessary for a covered person, emergency
7 services or emergency services of the type determined unnecessary by the screening need not be covered
8 by the health carrier unless otherwise covered under the health benefit plan. However, if screening
9 determines that emergency services or emergency services of a particular type are necessary, those
10 services must be covered by the health carrier. A health carrier shall cover emergency services if the health
11 carrier, acting through a participating provider or other authorized representative, has authorized the
12 provision of emergency services.

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

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

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

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

27

28 **NEW SECTION. Section 18. Use of intermediaries -- responsibilities of health carriers,**
29 **intermediaries, and providers.** (1) A health carrier is responsible for complying with applicable provisions
30 of [sections 8 through 29], and contracting with an intermediary for all or some of the services for which

1 a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

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

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

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

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

17 (6) An intermediary shall allow the COMMISSIONER AND THE department access to the
18 intermediary's books, records, claim information, billing information, and other documentation of services
19 provided to covered persons that are required by any of those entities to determine compliance with
20 [sections 13 through 21] and the rules implementing [sections 13 through 21].

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

24

25 NEW SECTION. Section 19. Contract filing requirements -- material changes -- state access to
26 contracts. (1) On October 1, ~~1998~~ 1999, a health carrier offering a managed care plan shall file with the
27 department sample contract forms proposed for use with its participating providers and intermediaries.

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

1 considered a material change for the purpose of this subsection.

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

5

6 **NEW SECTION. Section 20. General contracting requirements.** (1) The execution of a contract
7 for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty
8 to provide health care services to a person with whom the health carrier has contracted and does not
9 relieve the health carrier of its responsibility for compliance with [sections 8 through 29] or the rules
10 implementing [sections 8 through 29].

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

13

14 **NEW SECTION. Section 21. Contract compliance dates.** (1) A contract between a health carrier
15 and a participating provider or intermediary in effect on October 1, ~~1997~~ 1999, must comply with [sections
16 13 through 21] and the rules implementing [sections 13 through 21] by ~~April~~ OCTOBER 1, 1999. The
17 department may extend the ~~April~~ OCTOBER 1 date for an additional period of up to 6 months if the health
18 carrier demonstrates good cause for an extension.

19 (2) A contract between a health carrier and a participating provider or intermediary issued or put
20 into effect on or after ~~April 1, 1998~~ OCTOBER 1, 1999, must comply with [sections 13 through 21] and
21 the rules implementing [sections 13 through 21] on the day that it is issued or put into effect.

22 (3) A contract between a health carrier and a participating provider or intermediary not described
23 in subsection (1) or (2) must comply with [sections 13 through 21] and the rules implementing [sections
24 13 through 21] by ~~April~~ OCTOBER 1, 1999.

25

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

28

29 **NEW SECTION. Section 23. Quality assurance -- national accreditation.** (1) A health carrier
30 whose managed care plan has been accredited by a nationally recognized accrediting organization shall

1 annually provide a copy of the accreditation and the accrediting standards used by the accrediting
2 organization to the department.

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

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

8 (4) [Section 24] does not apply to a health carrier's managed care plan if the health carrier
9 maintains current accreditation by a nationally recognized accrediting organization whose standards meet
10 or exceed state quality assurance standards adopted pursuant to [sections 23 through 27].

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

13
14 **NEW SECTION. Section 24. Standards for health carrier quality assessment programs.** A health
15 carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure
16 systems sufficient to accurately measure the quality of health care services provided to covered persons
17 on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this
18 requirement, a health carrier shall:

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

22 (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory
23 agencies, providers, and consumers as provided in [section 26];

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

27 (4) file a written description of the quality assessment program and any subsequent material
28 changes with the department in a format that must be prescribed by rules of the department. The
29 description must include a signed certification by a corporate officer of the health carrier that the health
30 carrier's quality assessment program meets the requirements of [sections 23 through 27].

1 **NEW SECTION. Section 25. Standards for health carrier quality improvement programs.** A health
2 carrier that issues a closed plan or a combination plan shall, in addition to complying with [section 24],
3 adopt and use systems and methods necessary to improve the quality of health care provided in the health
4 carrier's managed care plan as indicated by the health carrier's quality assessment program and as required
5 by this section. To comply with this requirement, a health carrier subject to this section shall:

6 (1) establish an internal system capable of identifying opportunities to improve care;

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

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

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

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

19
20 **NEW SECTION. Section 26. Reporting and disclosure requirements.** (1) A health carrier offering
21 a closed plan or a combination plan shall document and communicate information, as required in this
22 section, about its quality assurance program. The health carrier shall:

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

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

27 (c) make available annually to providers and covered persons a report containing findings from its
28 quality assurance program and information about its progress in meeting internal goals and external
29 standards, when available.

30 (2) A health carrier shall certify to the department annually that its quality assurance program and

1 the materials provided to providers and consumers in accordance with subsection (1) meet the requirements
2 of [sections 23 through 27].

3 (3) A health carrier shall make available, upon request and payment of a reasonable fee, the
4 materials certified pursuant to subsection (2), except for the materials subject to the confidentiality
5 requirements of [section 27] and materials that are proprietary to the managed care plan. A health carrier
6 shall retain all certified materials for at least 3 years from the date that the material was certified or until
7 the material has been examined as part of a market conduct examination, whichever is later.

8
9 **NEW SECTION. Section 27. Confidentiality of health care and quality assurance records --**
10 **disclosure.** (1) Except as provided in subsection (2), the following information held by a health carrier
11 offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a
12 person:

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

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

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

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

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

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

26 or

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

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

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

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

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

6
 7 **NEW SECTION. Section 28. Enforcement.** (1) If the department ~~(OR THE BOARD)~~ determines that
 8 a health carrier has not complied with [sections 8 through 29] or the rules implementing [sections 8 through
 9 29], the department ~~(OR THE BOARD)~~ may recommend corrective action to the health carrier.

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

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

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

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

19 (d) the commissioner determines that a health carrier has violated or is violating [sections 8 through
 20 29] or the rules implementing [sections 8 through 29].

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

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

25 (b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part

26 3.

27
 28 **NEW SECTION. Section 29. Jurisdiction over contract actions.** The district courts have jurisdiction
 29 over actions for the enforcement of contracts authorized or regulated by [sections 8 through 29].
 30

1 ~~NEW SECTION. SECTION 30. DEFINITIONS. AS USED IN [SECTIONS 8 THROUGH 29], THE~~
2 ~~FOLLOWING DEFINITIONS APPLY:~~

3 ~~(1) "BOARD" MEANS THE BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE~~
4 ~~PROVIDED FOR IN [SECTION 31].~~

5 ~~(2) "CLOSED PLAN" MEANS A MANAGED CARE PLAN THAT REQUIRES COVERED PERSONS TO~~
6 ~~USE ONLY PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.~~

7 ~~(3) "COMBINATION PLAN" MEANS AN OPEN PLAN WITH A CLOSED COMPONENT.~~

8 ~~(4) "COVERED BENEFITS" MEANS THOSE HEALTH CARE SERVICES TO WHICH A COVERED~~
9 ~~PERSON IS ENTITLED UNDER THE TERMS OF A HEALTH BENEFIT PLAN.~~

10 ~~(5) "COVERED PERSON" MEANS A POLICYHOLDER, SUBSCRIBER, OR ENROLLEE OR OTHER~~
11 ~~INDIVIDUAL PARTICIPATING IN A HEALTH BENEFIT PLAN.~~

12 ~~(6) "DEPARTMENT" MEANS THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES~~
13 ~~ESTABLISHED IN 2-15-2201.~~

14 ~~(7) "EMERGENCY MEDICAL CONDITION" MEANS A CONDITION MANIFESTING ITSELF BY~~
15 ~~SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, THAT THE ABSENCE OF IMMEDIATE~~
16 ~~MEDICAL ATTENTION COULD REASONABLY BE EXPECTED TO RESULT IN ANY OF THE FOLLOWING:~~

17 ~~(A) THE COVERED PERSON'S HEALTH WOULD BE IN SERIOUS JEOPARDY;~~

18 ~~(B) THE COVERED PERSON'S BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR~~

19 ~~(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.~~

20 ~~(8) "EMERGENCY SERVICES" MEANS HEALTH CARE ITEMS AND SERVICES FURNISHED OR~~
21 ~~REQUIRED TO EVALUATE AND TREAT AN EMERGENCY MEDICAL CONDITION.~~

22 ~~(9) "FACILITY" MEANS AN INSTITUTION PROVIDING HEALTH CARE SERVICES OR A HEALTH~~
23 ~~CARE SETTING, INCLUDING BUT NOT LIMITED TO A HOSPITAL, MEDICAL ASSISTANCE FACILITY, AS~~
24 ~~DEFINED IN 50-5-101, OR OTHER LICENSED INPATIENT CENTER, AN AMBULATORY SURGICAL OR~~
25 ~~TREATMENT CENTER, A SKILLED NURSING CENTER, A RESIDENTIAL TREATMENT CENTER, A~~
26 ~~DIAGNOSTIC, LABORATORY, OR IMAGING CENTER, OR A REHABILITATION OR OTHER THERAPEUTIC~~
27 ~~HEALTH SETTING.~~

28 ~~(10) "HEALTH BENEFIT PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT~~
29 ~~ENTERED INTO, OFFERED, OR ISSUED BY A HEALTH CARRIER TO PROVIDE, DELIVER, ARRANGE FOR,~~
30 ~~PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES.~~

1 ~~(11) "HEALTH CARE PROFESSIONAL" MEANS A PHYSICIAN OR OTHER HEALTH CARE~~
2 ~~PRACTITIONER LICENSED, ACCREDITED, OR CERTIFIED PURSUANT TO THE LAWS OF THIS STATE TO~~
3 ~~PERFORM SPECIFIED HEALTH CARE SERVICES CONSISTENT WITH STATE LAW.~~

4 ~~(12) "HEALTH CARE PROVIDER" OR "PROVIDER" MEANS A HEALTH CARE PROFESSIONAL OR~~
5 ~~A FACILITY.~~

6 ~~(13) "HEALTH CARE SERVICES" MEANS SERVICES FOR THE DIAGNOSIS, PREVENTION,~~
7 ~~TREATMENT, CURE, OR RELIEF OF A HEALTH CONDITION, ILLNESS, INJURY, OR DISEASE.~~

8 ~~(14) "HEALTH CARRIER" MEANS AN ENTITY SUBJECT TO THE INSURANCE LAWS AND RULES~~
9 ~~OF THIS STATE THAT CONTRACTS, OFFERS TO CONTRACT, OR ENTERS INTO AN AGREEMENT TO~~
10 ~~PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE~~
11 ~~SERVICES, INCLUDING A DISABILITY INSURER, HEALTH MAINTENANCE ORGANIZATION, OR HEALTH~~
12 ~~SERVICE CORPORATION OR ANOTHER ENTITY PROVIDING A HEALTH BENEFIT PLAN.~~

13 ~~(15) "INTERMEDIARY" MEANS A PERSON AUTHORIZED TO NEGOTIATE, EXECUTE, AND BE A~~
14 ~~PARTY TO A CONTRACT BETWEEN A HEALTH CARRIER AND A PROVIDER OR BETWEEN A HEALTH~~
15 ~~CARRIER AND A NETWORK.~~

16 ~~(16) "MANAGED CARE PLAN" MEANS A HEALTH BENEFIT PLAN THAT EITHER REQUIRES OR~~
17 ~~CREATES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR A COVERED PERSON TO USE HEALTH~~
18 ~~CARE PROVIDERS MANAGED, OWNED, UNDER CONTRACT WITH, OR EMPLOYED BY A HEALTH~~
19 ~~CARRIER, BUT NOT PREFERRED PROVIDER ORGANIZATIONS OR OTHER PROVIDER NETWORKS~~
20 ~~OPERATED IN A FEE FOR SERVICE INDEMNITY ENVIRONMENT.~~

21 ~~(17) "MEDICALLY NECESSARY" MEANS SERVICES OR SUPPLIES THAT ARE NECESSARY AND~~
22 ~~APPROPRIATE FOR THE TREATMENT OF A COVERED PERSON'S EMERGENCY MEDICAL CONDITION OR~~
23 ~~FOR THE PREVENTIVE CARE OF A COVERED PERSON ACCORDING TO ACCEPTED STANDARDS OF~~
24 ~~MEDICAL PRACTICE.~~

25 ~~(18) "NETWORK" MEANS THE GROUP OF PARTICIPATING PROVIDERS THAT PROVIDES HEALTH~~
26 ~~CARE SERVICES TO A MANAGED CARE PLAN.~~

27 ~~(19) "OPEN PLAN" MEANS A MANAGED CARE PLAN OTHER THAN A CLOSED PLAN THAT~~
28 ~~PROVIDES INCENTIVES, INCLUDING FINANCIAL INCENTIVES, FOR COVERED PERSONS TO USE~~
29 ~~PARTICIPATING PROVIDERS UNDER THE TERMS OF THE MANAGED CARE PLAN.~~

30 ~~(20) "PARTICIPATING PROVIDER" MEANS A PROVIDER WHO, UNDER A CONTRACT WITH A~~

~~1 HEALTH CARRIER OR WITH THE HEALTH CARRIER'S CONTRACTOR, SUBCONTRACTOR, OR
2 INTERMEDIARY, HAS AGREED TO PROVIDE HEALTH CARE SERVICES TO COVERED PERSONS WITH AN
3 EXPECTATION OF RECEIVING PAYMENT, OTHER THAN COINSURANCE, COPAYMENTS, OR
4 DEDUCTIBLES, DIRECTLY OR INDIRECTLY FROM THE HEALTH CARRIER.~~

~~5 (21) "PRIMARY CARE PROFESSIONAL" MEANS A PARTICIPATING HEALTH CARE PROFESSIONAL
6 DESIGNATED BY THE HEALTH CARRIER TO SUPERVISE, COORDINATE, OR PROVIDE INITIAL CARE OR
7 CONTINUING CARE TO A COVERED PERSON AND WHO MAY BE REQUIRED BY THE HEALTH CARRIER
8 TO INITIATE A REFERRAL FOR SPECIALTY CARE AND TO MAINTAIN SUPERVISION OF HEALTH CARE
9 SERVICES RENDERED TO THE COVERED PERSON.~~

~~10 (22) "QUALITY ASSESSMENT" MEANS THE MEASUREMENT AND EVALUATION OF THE QUALITY
11 AND OUTCOMES OF MEDICAL CARE PROVIDED TO INDIVIDUALS, GROUPS, OR POPULATIONS.~~

~~12 (23) "QUALITY ASSURANCE" MEANS QUALITY ASSESSMENT AND QUALITY IMPROVEMENT.~~

~~13 (24) "QUALITY IMPROVEMENT" MEANS AN EFFORT TO IMPROVE THE PROCESSES AND
14 OUTCOMES RELATED TO THE PROVISION OF HEALTH CARE SERVICES WITHIN A HEALTH PLAN.~~

~~15
16 NEW SECTION. SECTION 31. BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE.~~

~~17 (1) THERE IS A BOARD OF NETWORK ADEQUACY AND QUALITY ASSURANCE. THE BOARD IS
18 COMPOSED OF A MEDICAL DIRECTOR, THE DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH AND
19 HUMAN SERVICES, PROVIDED FOR IN 2-15-2201, AND THE COMMISSIONER OF INSURANCE, PROVIDED
20 FOR IN 2-15-1903.~~

~~21 (2) THE MEDICAL DIRECTOR IS APPOINTED BY THE GOVERNOR AND MUST BE LICENSED AS
22 A PHYSICIAN BY THE STATE OF MONTANA. THE MEDICAL DIRECTOR MUST BE A SPECIALIST IN
23 EITHER FAMILY PRACTICE OR INTERNAL MEDICINE. THE GOVERNOR MAY REMOVE A MEDICAL
24 DIRECTOR AT ANY TIME AND APPOINT A NEW MEDICAL DIRECTOR TO THE POSITION.~~

~~25 (3) THE GENERAL POWERS AND DUTIES OF THE BOARD ARE PROVIDED IN [SECTION 32].~~

~~26 (4) THE BOARD IS ATTACHED FOR ADMINISTRATIVE PURPOSES TO THE DEPARTMENT
27 PURSUANT TO 2-15-121.~~

~~28
29 NEW SECTION. SECTION 32. BOARD - GENERAL POWERS AND DUTIES. THE BOARD SHALL:~~

~~30 (1) PERIODICALLY REVIEW THE STATE NETWORK ADEQUACY AND QUALITY ASSURANCE~~

1 ~~STANDARDS PROVIDED IN SECTIONS 8 THROUGH 29] AND THE RULES IMPLEMENTING SECTIONS 8~~
 2 ~~THROUGH 29];~~

3 ~~(2) RECOMMEND CORRECTIVE ACTION NECESSARY FOR THE HEALTH CARRIER TO ACHIEVE~~
 4 ~~COMPLIANCE WITH STATE NETWORK ADEQUACY AND QUALITY ASSURANCE STANDARDS; AND~~

5 ~~(3) RECOMMEND ACTION TO THE COMMISSIONER AGAINST A HEALTH CARRIER WHOSE~~
 6 ~~MANAGED CARE PLAN DOES NOT COMPLY WITH STANDARDS FOR NETWORK ADEQUACY AND~~
 7 ~~QUALITY ASSURANCE ADOPTED BY THE BOARD.~~

8

9 NEW SECTION. Section 30. Codification instruction. (1) [Section 7] is intended to be codified as
 10 an integral part of Title 33, chapter 31, and the provisions of Title 33, chapter 31, apply to [section 7].

11 (2) [Sections 8 through ~~29-32~~ 29] are intended to be codified as an integral part of Title 33, and
 12 the provisions of Title 33 apply to [sections 8 through ~~29-32~~ 29].

13

14 NEW SECTION. Section 31. Severability. If a part of [this act] is invalid, all valid parts that are
 15 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its
 16 applications, the part remains in effect in all valid applications that are severable from the invalid
 17 applications.

18

19 NEW SECTION. Section 32. Applicability. [This act] applies to a health carrier as defined in
 20 [section 10] who offers a managed care plan as defined in [section 10] on or after [the effective date of
 21 this section].

22

23 NEW SECTION. Section 33. Effective dates. (1) Except as provided in subsections (2) and (3),
 24 [this act] is effective January 1, 1998.

25 (2) [Sections ~~12, 22, and 30~~ through ~~32, 33 THROUGH 35, AND 37 AND 30 THROUGH 32~~ and
 26 this section] are effective on passage and approval.

27 (3) [Sections ~~13, 15, 18 THROUGH 21, AND~~ 23 through ~~26~~ 29] are effective October 1, 1999.

28 ~~(4) SECTIONS 30 THROUGH 32] AND THE LANGUAGE IN BRACKETS IN SECTIONS 9, 12, AND~~
 29 ~~28] ARE EFFECTIVE JULY 1, 2001.~~

30

1 ~~NEW SECTION. SECTION 37. TERMINATION. [SECTION 10] TERMINATES JUNE 30, 2001.~~

2 -END-