TITLE 41
INSURANCE

CHAPTER 39
MANAGED CARE REFORM

41-3901. SHORT TITLE. This chapter may be cited as the Idaho "Managed Care Reform Act."

[41-3901, added 1974, ch. 177, sec. 1, p. 1444; am. 1997, ch. 204, sec. 2, p. 582.]

41-3902. INTENT AND PURPOSE. As a guide to the interpretation and application of this chapter, the public policy of this state is declared as follows: The legislature wishes to eliminate legal barriers to the establishment of managed care plans which provide readily available, accessible and quality health care to their members and to encourage their development as an optional method of health care delivery. The state of Idaho must have reasonable assurance that organizations offering managed care plans within this state are financially and administratively sound and responsive to the needs of their members, and that such organizations are, in fact, able to deliver the benefits which they offer.

[41-3902, added 1974, ch. 177, sec. 2, p. 1444; am. 1997, ch. 204, sec. 3, p. 582.]

41-3903. DEFINITIONS. (1) "Basic health care services" means the following services: preventive care, emergency care, inpatient and outpatient hospital and physician care, hospital-based rehabilitation treatment, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

(2) "Coinsurance" means a percentage amount a member is responsible to pay out-of-pocket for health care services after satisfaction of any applicable deductibles or copayments, or both.

(3) "Copayment" means an amount a member must pay to a provider in payment for a specific health care service which is not fully prepaid.

(4) "Deductible" means the amount of expense a member must first incur before the managed care organization begins payment for covered services.

(5) "Director" means the director of the department of insurance of the state of Idaho.

(6) "Emergency facility" means any hospital or other facility where emergency services are provided to a member including, but not limited to, a physician's office.

(7) "Emergency services" means those health care services that are provided in a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in:

(a) Placing the patient's health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(8) "Employer" means any person, firm, corporation, partnership or association.

(9) "Enrollee" means a person who either individually or through a group has entered into a contract for services under a managed care plan.

(10) "General managed care plan" means a managed care plan which provides directly or arranges to provide, at a minimum, basic health care services. A general managed care plan shall include basic health care services.

(11) "Health care contract" means a contract entered into by a managed care organization and an enrollee.

(12) "Health care services" means those services offered or provided by health care facilities and health care providers relating to the prevention, cure or treatment of illness, injury or disease.

(13) "Limited managed care plan" means a managed care plan which provides dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services or such other services as the director may establish by rule to be limited health care services. Limited health care services shall not include hospital, medical, surgical or emergency services except as those services are provided incident to limited health care services.

(14) "Managed care organization" means a public or private person or organization which offers a managed care plan. Unless otherwise specifically stated, the provisions of this chapter shall apply to any person or organization offering a managed care plan, whether or not a certificate of authority to offer the plan is required under this chapter.

(15) "Managed care plan" means a contract of coverage given to an individual, family or group of covered individuals pursuant to which a member is entitled to receive a defined set of health care benefits through an organized system of health care providers in exchange for defined consideration and which requires the member to use, or creates financial incentives for the member to use, health care providers owned, managed, employed by or under contract with the managed care organization. A person holding a license to transact disability insurance offering a health plan that creates financial incentives to use contracting providers may elect to file the plan as a nonmanaged care plan not subject to the provisions of this chapter if the health plan reimburses providers solely on a fee for service basis and does not require the selection of a primary care provider. The election to file a health plan as a nonmanaged care plan shall be made in writing at the time the plan is filed with the director pursuant to chapter 18, title 41, Idaho Code.

(16) "Member" means a policyholder, enrollee or other individual participating in a managed care plan.

(17) "Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, corporations or other legally recognized entities.

(18) "Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

(19) "Utilization management program" means a system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a managed care plan using specified guidelines. Such a system may include, but is not limited to, preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures and retrospective review.

[41-3903, added 1997, ch. 204, sec. 5, p. 582; am. 1998, ch. 142, sec. 1, p. 505; am. 2004, ch. 283, sec. 2, p. 799.]

41-3904. CERTIFICATE OF AUTHORITY REQUIRED -- EXCEPTIONS -- APPLICATION OF CERTAIN PROVISIONS. (1) No person shall in this state offer a managed care plan on a predetermined and prepaid basis, unless authorized under a certificate of authority issued by the director. A person offering a managed care plan on a predetermined and prepaid basis is deemed to be transacting the business of insurance.

(2) An organization proposing to offer a managed care plan on a predetermined and prepaid basis, after it has filed its application for a certificate of authority as provided in section 41-3906, Idaho Code, and while its application is pending, if permitted by and in accordance with rules promulgated by the director, may inform the public concerning its proposed health care services.

(3) Entities not offering a managed care plan shall not be subject to the provisions of this chapter.

(4) An entity not required to obtain a certificate of authority which holds itself out to the public or markets itself as an organization rendering basic health care services to a specified population through a managed care plan shall be subject to and must comply with the following sections of this chapter but shall not be subject to regulation by the department: 41-3902; 41-3903; 41-3904; 41-3909(1) and (2); 41-3914(1) and (2); 41-3915(1), (2), (3), (4), (5), (6) and (8); 41-3916; 41-3917; 41-3918(1), (2) and (4); 41-3919(1) and (2); 41-3920; 41-3921(2), (3) and (4); 41-3922(2); 41-3926; 41-3927; 41-3928; 41-3930 and 41-3932, Idaho Code.

[41-3904, added 1974, ch. 177, sec. 4, p. 1444; am. 1997, ch. 204, sec. 6, p. 584; am. 2003, ch. 304, sec. 14, p. 839.]

41-3905. QUALIFICATIONS FOR CERTIFICATE OF AUTHORITY. The director shall not issue or permit to remain in force a certificate of authority authorizing the transaction of managed care plans unless the organization offering the managed care plan is qualified therefor as follows:

(1) It must be empowered to engage in business as a managed care organization under its articles or certificate of incorporation, or of association, or partnership agreement, or other basic organizational document, as the case may be.

(2) It must be financially responsible, and have such funds and financial resources as may reasonably be expected to enable it to fulfill its obligations to its members. An organization offering a general managed care plan must comply with the capital and surplus requirements of a disability insurer under the provisions of section 41-313, Idaho Code. The director shall determine the surplus required of an organization offering a limited managed care plan, which shall be not less than twenty-five thousand dollars ($25,000) or such increased amount as the director may find reasonably necessary by the scope of the organization's proposed operations. As to financial resources of an organization offering a limited managed care plan the director may, among other relevant factors, also consider:

(a) Any agreements with an insurer, professional service corporation, governmental agency, or other responsible organization to underwrite, insure payment for or provide the proposed services;

(b) Agreements with providers for the provision of the proposed services;

(c) Arrangements for liability insurance, or an adequate plan of self-insurance, as to claims for loss or injury arising out of managed care operations;

(d) Reinsurance agreements; and

(e) Deposit requirements under subsection (7) of this section.

(3) It must propose to provide health care services on a predetermined and prepaid basis and indemnity benefits covering all or a portion of the cost of out-of-area services, out-of-network services and emergency services; provided, however, that except for care provided by primary care providers, who shall include at least those categories of providers listed in section 41-3915(2)(e), Idaho Code, a managed care organization may require a determination that a member needs care from a category of provider not listed in section 41-3915(2)(e), Idaho Code, before a member may access out-of-network nonemergency care from a provider not listed in section 41-3915(2)(e), Idaho Code.

(4) It must have the intent to render and capability for rendering or providing coverage for good quality health care services, which will be and are readily available and accessible to members in each geographic area in which it proposes to operate or operates, and such services must be reasonably responsive to the needs of members.

(5) Its procedures for offering health care services, and for offering and terminating health care contracts, must be reasonable and equitable.

(6) It must propose to establish, and after authorization in fact establish and maintain, reasonable and adequate procedures to:

(a) Monitor the quality of health care provided, including a reasonable system of internal peer review of diagnosis and treatment of members' health conditions;

(b) Resolve grievances of members, as required by section 41-3918, Idaho Code; and

(c) Provide members with an opportunity to participate in matters of policy and operation as required by section 41-3916, Idaho Code.

(7) It must comply with the deposit requirements of section 41-316 or 41-316A, Idaho Code, as applicable; provided however, that the amount of the deposit required of an organization offering a limited managed care plan shall be not less than twenty-five thousand dollars ($25,000) or such increased amount as the director may find reasonably necessary by the scope of the organization's proposed operations.

(8) Notwithstanding anything to the contrary in this chapter, the director may allow a period of up to three (3) years following the issuance of a certificate of authority to a managed care organization after the effective date of this act to comply with the capital, surplus and deposit requirements of this chapter. The director shall establish minimum initial amounts and minimum increases in capital, surplus and deposits for such certificate holder based upon the number of enrolled members in its managed care plans. If the certificate holder fails to meet the capital, surplus or deposit requirements within the time herein allowed, the organization shall no longer be authorized to offer managed care plans on a predetermined and prepaid basis in this state. If the organization fails to meet the minimum increases established by the director, the organization shall cease to market its plans upon notice from the director.

(9) Notwithstanding anything to the contrary in this chapter, a managed care organization holding a valid Idaho certificate of authority to transact insurance as a health maintenance organization on or before the effective

date of this act may have up to three (3) years from and after that date within which to comply with the increases in capital, surplus and deposit requirements imposed by this act. The director shall establish minimum increases in capital, surplus and deposits for the certificate holder based upon the number of enrolled members in its managed care plans. If the certificate holder fails to meet the capital, surplus or deposit requirements within the time herein allowed, the organization shall no longer be authorized to offer managed care plans on a predetermined and prepaid basis in this state. If the organization fails to meet the minimum increases established by the director, the organization shall cease to market its plans upon notice from the director.

[41-3905, added 1974, ch. 177, sec. 5, p. 1444; am. 1997, ch. 204, sec. 7, p. 584; am. 2008, ch. 203, sec. 1, p. 651.]

41-3906. APPLICATION FOR CERTIFICATE OF AUTHORITY. (1) The application for a certificate of authority shall be in writing in the form prescribed by the director. It shall be verified by an officer of an applicant corporation or association, or member of an applicant firm, or by the applicant if an individual. The application shall set forth or be accompanied by:

(a) a copy of the basic organizational document of the applicant, such as articles of incorporation or of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(b) a copy of the bylaws, rules, or similar document regulating conduct of the applicant's internal affairs;

(c) a listing of the names, addresses, principal occupations, and official positions of the individuals who are to be responsible for the conduct of applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(d) a copy of any contract made or to be made between the applicant and any provider, and the applicant and any person named in subsection (c) hereof;

(e) a statement generally describing the managed care organization, its health care plan or plans, facilities, and personnel;

(f) a copy of each form of health care contract proposed to be issued;

(g) financial statements showing the applicant's audited assets, liabilities, and sources and amount of financial support. A copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the director directs that additional or more recent financial information is required for proper administration of this chapter;

(h) a financial plan, which includes a three (3) year projection of initial operating results anticipated, and a statement as to the sources of working capital as well as any other source of funding;

(i) a description of the proposed method of marketing the plan;

(j) a statement of the geographic area or areas to be served;

(k) a description of the grievance procedures as required under section 41-3918, Idaho Code;

(l) a description of the system and procedures for monitoring the quality of health care services as required by section 41-3905(6)(a), Idaho Code;

(m) a description of the mechanism by which members will be given an opportunity to participate in matters of policy and operation as required by section 41-3916, Idaho Code;

(n) if the applicant is not domiciled in this state, a power of attorney duly executed by the applicant and irrevocably appointing the director and his successors in office as the applicant's attorney upon whom may be served all lawful process in any legal action or proceeding against the managed care organization on a cause of action arising in this state; and

(o) such other information as the director may reasonably require as to the applicant's qualifications as a managed care organization.

(2) Every organization authorized to offer a managed care plan under a certificate of authority issued prior to July 1, 1997, shall comply with any new or additional requirements, other than applicable capital, surplus and deposit requirements, imposed by this act by January 1, 1998. If the organization does not comply by January 1, 1998, the organization shall no longer be authorized to offer managed care plans on a predetermined and prepaid basis in this state.

[41-3906, added 1974, ch. 177, sec. 6, p. 1444; am. 1980, ch. 197, sec. 31, p. 455; am. 1997, ch. 204, sec. 8, p. 587.]

41-3909. RECORDS. (1) Every managed care organization shall establish and at all times maintain adequate records of its financial and business transactions.

(2) The managed care organization shall retain its general records with respect to a particular transaction for a period of not less than seven (7) years after termination of the transaction, and health records shall be retained for a period of seven (7) years after the termination of the member's contract.

(3) The managed care organization shall make all records available to the director or his designee for review at all reasonable times upon the director's request; provided, however, that the availability of health records shall be subject to any Idaho law limiting or defining such availability.

[41-3909, added 1974, ch. 177, sec. 9, p. 1444; am. 1997, ch. 204, sec. 10, p. 588.]

41-3910. REPORTS TO THE DIRECTOR. (1) Every managed care organization offering a managed care plan for which a certificate of authority is required shall annually, on or before the first day of June, file a report with the director showing its audited financial condition on the last day of the preceding December. The report shall be on forms prescribed by the director and shall be verified by an appropriate officer of the organization.

(2) Such report shall include:

(a) A financial statement of the organization, including its balance sheet and statement of income and expenditures for the preceding year certified by an independent public accountant;

(b) Any changes in the information submitted in connection with its application for certificate of authority;

(c) Such other information as is available to the managed care organization relating to the operations of the organization as the director

may require by rule to enable him to carry out his duties under this chapter.

[41-3910, added 1974, ch. 177, sec. 10, p. 1444; am. 1997, ch. 204, sec. 11, p. 589; am. 2008, ch. 203, sec. 2, p. 653.]

41-3911. EXAMINATIONS. (1) The director shall make an examination of the affairs and operations of any organization offering a managed care plan for which a certificate of authority is required as often as he deems necessary but not less frequently than once every five (5) years.

(2) Every such organization shall upon the director's request submit its books and records relating to its affairs and operations to such examination and shall facilitate the examination.

(3) Health records of individuals and records of providers providing services under a contract with the managed care organization shall not be subject to such examination, except as provided in section 41-3909(3), Idaho Code.

(4) At the direction of the director, the expenses of examination shall be borne by the organization being examined in accordance with section 41-228, Idaho Code.

[41-3911, added 1974, ch. 177, sec. 11, p. 1444; am. 1997, ch. 204, sec. 12, p. 589; am. 2001, ch. 85, sec. 11, p. 219.]

41-3912. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY. The director may initiate proceedings to suspend or revoke a certificate of authority to offer a managed care plan for the reasons and in the manner provided in title 41, Idaho Code, for mutual insurers. In addition to any other penalties, the director may impose a penalty upon the managed care organization of up to fifteen thousand dollars ($15,000) for each and every unlawful act committed.

[41-3912, added 1997, ch. 204, sec. 14, p. 590.]

41-3914. ANNUAL DISCLOSURES. (1) Every managed care organization shall provide to its enrollees and make available for inspection by the general public on an annual basis:

(a) an audited statement of financial condition including a balance sheet and a summary of receipts and disbursements;

(b) a description of the accessibility and availability of services, including a list of the providers currently participating in the managed care plan and of the providers who are accepting new patients, the addresses of primary care physicians and participating hospitals and the specialty of each physician and category of the other participating providers;

(c) a statement as to whether the plan includes a limited formulary of medications, and a statement that the formulary will be made available to any prospective member or member upon request;

(d) a clear and understandable description of the managed care organization's method of resolving member grievances;

(e) a description of how the qualifications of participating providers may be obtained;

(f) such other information as the director may by rule prescribe.

(2) In addition to matters specified in subsection (1) of this section, each managed care organization shall make available for public inspection a description of the benefit package or packages offered to each class of members and their rates. Such information shall be presented in clear, readable, and concise form and shall include, at a minimum, a description of all of the material elements required of health care contracts.

(3) A managed care organization for which a certificate of authority is required shall furnish a copy of the information required by this section to the department upon request of the director.

[41-3914, added 1974, ch. 177, sec. 14, p. 1444; am. 1978, ch. 360, sec. 1, p. 947; am. 1997, ch. 204, sec. 16, p. 590; am. 2008, ch. 203, sec. 3, p. 653.]

41-3915. HEALTH CARE CONTRACTS. (1) All health care contracts or other marketing documents describing health care services offered by any managed care organization shall contain:

(a) A complete description of the health care services and other benefits to which the member is entitled;

(b) A description of the accessibility and availability of services, including a list of the providers participating in the managed care plan and of the providers who are accepting new patients, the addresses of primary care physicians and participating hospitals, and the specialty of each physician and category of the other participating providers. The information required by this subsection (1)(b) may be contained in a separate document and incorporated in the contract by reference and shall be amended from time to time as necessary to provide members with the most current information;

(c) Any predetermined and prepaid rate of payment for health care services and for other benefits, if any, and any services or benefits for which the member is obliged to pay, including member responsibility for deductibles, copayments, and coinsurance;

(d) All exclusions and limitations on services or other benefits including all restrictions relating to preexisting conditions;

(e) A statement as to whether the plan includes a limited formulary of medications and a statement that the formulary will be made available to any member on request;

(f) All criteria by which a member may be terminated or denied reenrollment;

(g) Service priorities in case of epidemic, or other emergency conditions affecting demand for health care services;

(h) A statement that members shall not, under any circumstances, be liable, assessable or in any way subject to payment for the debts, liabilities, insolvency, impairment or any other financial obligations of the managed care organization;

(i) Grievance procedures;

(j) Procedures for notifying enrollees of any change in benefits; and

(k) A description of all prior authorization review procedures for health care services.

(2) In addition to the requirements of subsection (1) of this section, an organization offering a general managed care plan shall:

(a) Establish procedures for members to select or change primary care providers;

(b) Establish procedures to notify members of the termination of their primary care provider and the manner in which the managed care organization will assist members in transferring to another participating primary care provider;

(c) Establish referral procedures for specialty care and procedures for after-hours, out-of-network, out-of-area and emergency care;

(d) Allow members direct access to network obstetricians and gynecologists for maternity care, annual visits, and follow-up gynecological care for conditions diagnosed during maternity care or annual visits;

(e) Allow family practice and general practice physicians, general internists, pediatricians, obstetricians, and gynecologists to be included in the general managed care plan's listing of primary care providers.

(3) No managed care organization shall cancel the enrollment of a member or refuse to transfer a member from a group to an individual basis for reasons relating to age, sex, race, religion, occupation, or health status. However, nothing contained herein shall prevent termination of a member who has violated any published policies of the organization, which have been approved by the director.

(4) No managed care organization shall contract with any provider under provisions which require a member to guarantee payment, other than specified copayments, deductibles and coinsurance to such provider in the event of nonpayment by the managed care organization for any services rendered under contract directly or indirectly between the member and the managed care organization.

(5) No health care provider shall require a member to make additional payments for covered services under a health care contract, other than specified deductibles, copayments, or coinsurance once a provider has agreed in writing to accept the managed care organization's reimbursement rate to provide a covered service.

(6) The rates charged by any managed care organization to its members shall not be excessive, inadequate, or unfairly discriminatory. The director may define by rule what constitutes excessive, inadequate or unfairly discriminatory rates and may require a description of the actuarial assumptions and analysis upon which such rates are based as well as whatever other information, available to the managed care organization, he deems necessary to determine that a rate or proposed rate meets the requirements of this subsection. If experience rating is a common health insurance practice in the area served by the managed care organization, it shall have the right to experience-rate its own contracts.

(7) No such contract form or amendment to an approved contract form shall be issued unless it has been filed with the director. The contract form or amendment shall become effective thirty (30) days after such filing unless specifically disapproved by the director. Any such disapproval shall be based on the requirements of section 41-3905, Idaho Code, or subsection (1), (2), (4), (5) or (6) of this section.

(8) The director shall disapprove any contract which, with amendments, does not constitute the entire contractual obligation between the parties involved. No portion of the charter, bylaws, or other constituent document of the managed care organization shall constitute part of such a contract unless set forth in full therein or incorporated by reference as authorized in this section.

[41-3915, added 1974, ch. 177, sec. 15, p. 1444; am. 1997, ch. 204, sec. 17, p. 590; am. 1998, ch. 421, sec. 1, p. 1330.]

41-3916. ADVISORY PANELS. Every managed care organization shall establish a mechanism to provide members an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other reasonable mechanisms. As a minimum, such an advisory panel shall be required to review and comment upon any proposed changes to: (a) the managed care plan's grievance procedures, and (b) nongroup member benefit packages and prepayments, prior to implementation of such policy. The substance of such comments shall be distributed to the affected members at the time notification of such policy changes are made.

[41-3916, added 1974, ch. 177, sec. 16, p. 1444; am. 1978, ch. 361, sec. 1, p. 948; am. 1997, ch. 204, sec. 18, p. 593.]

41-3917. CERTAIN WORDS PROHIBITED IN NAME OF ORGANIZATION. No person or organization offering a health care plan not qualified as a managed care plan under the provisions of this chapter shall use in its name, logo, contracts or literature the phrase, "health maintenance organization," "managed care organization," "general managed care organization" or "limited managed care organization" or the initials "HMO," "MCO," "GMCO," or "LMCO."

[41-3917, added 1974, ch. 177, sec. 17, p. 1444; am. 1997, ch. 204, sec. 19, p. 593.]

41-3918. GRIEVANCE SYSTEM. (1) Every managed care organization shall establish a grievance system to resolve grievances initiated by members concerning health care services. The system shall provide reasonable procedures for the resolution of grievances, and shall include an appeals process which affords the member the right to a prompt review by a grievance panel before whom the member has the right either to appear or be heard, or both. A managed care organization offering a managed care plan for which a certificate of authority is required shall have its grievance system approved by the director and shall submit to the director an annual report in a form prescribed by the director which shall include:

(a) A description of the procedures of the grievance system; and

(b) The total number of grievances handled through the grievance system and a compilation of causes underlying the grievances filed.

(2) Every managed care organization shall maintain records of grievances filed with it concerning health care services and each managed care organization for which a certificate of authority is required shall submit to the director a summary report at such times and in such form as the director may require. Grievances involving other persons shall be referred to such persons with a copy to the director.

(3) The director may examine a grievance system of a managed care organization for which a certificate of authority is required, subject to the limitations concerning health records of individuals set forth in section 41-3909(3), Idaho Code.

(4) Every managed care organization must show evidence that such grievance procedures have been reviewed and approved by the member representatives through their participation on advisory panels or other reasonable mechanisms as set forth in section 41-3916, Idaho Code.

[41-3918, added 1974, ch. 177, sec. 18, p. 1444; am. 1997, ch. 204, sec. 20, p. 593; am. 2008, ch. 203, sec. 4, p. 654.]

41-3919. OPEN ENROLLMENT. (1) Requirement of an open enrollment period is intended to provide the benefits of managed care to the general public or to all members of the class of persons the managed care organization serves. Such requirement is not intended to prohibit a managed care organization from establishing administrative procedures that protect the quality of service to its members or the financial condition of the organization. However, during periods of open enrollment the organization shall not establish any administrative procedure that arbitrarily and unreasonably restricts enrollment.

(2) After the initial twenty-four (24) months of operation every managed care organization shall have an annual open enrollment period of at least one (1) month during which it accepts members, without restrictions up to the limits of its capacity except as provided in subsection (3) of this section, as determined by the managed care organization, in the order in which they apply for enrollment. Managed care organizations organized to provide services exclusively to a specified group or groups of individuals may limit such open enrollment to all members of such group(s).

(3) A managed care organization may apply to the director for authorization to impose underwriting restrictions upon enrollment. The director shall, within thirty (30) days, approve the application if he determines that such restrictions will:

(a) Preserve the financial stability of the managed care organization; or

(b) Prevent excessive adverse selection of prospective members; or

(c) Avoid unreasonably high or unmarketable charges for member coverage for health care services.

If the application cannot be approved the director must deny it within the thirty (30) day period.

[41-3919, added 1974, ch. 177, sec. 19, p. 1444; am. 1997, ch. 204, sec. 21, p. 594.]

41-3920. DISCRIMINATION AGAINST HEALTH PROFESSIONALS ASSOCIATED WITH MANAGED CARE ORGANIZATIONS. It shall be unlawful for any health service institution or associations of health professionals to exclude other health professionals from working privileges, membership, or association solely on the basis that such other person is employed by or contracts with a managed care organization pursuant to this chapter.

[41-3920, added 1974, ch. 177, sec. 20, p. 1444; am. 1997, ch. 204, sec. 22, p. 595.]

41-3921. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS. (1) Except as stated in this chapter, provisions of title 41, Idaho Code, applicable to disability insurers shall be applicable to the lawful transactions and business of an organization offering a managed care plan for which a certificate of authority is required pursuant to this chapter.

(2) With respect to all managed care organizations, the provision of factually accurate information regarding coverage, rates, locations and hours of service, names of affiliated institutions, and credentials of participating providers by the organization or its personnel to potential

members shall not constitute a violation of any law relating to solicitation or advertising by health care professionals.

(3) Any managed care organization which contracts with a health care facility or enters into arrangements with one (1) or more groups of providers organized on a group practice or individual practice basis shall not by virtue of such contracts or arrangements be deemed to have entered into a "conspiracy in restraint of trade".

(4) Except as expressly and specifically stated in this chapter, the provisions of chapter 34, title 41, Idaho Code, are not amended, repealed or otherwise affected by this chapter.

[41-3921, added 1974, ch. 177, sec. 21, p. 1444; am. 1988, ch. 265, sec. 573, p. 871; am. 1997, ch. 204, sec. 23, p. 595; am. 2015, ch. 251, sec. 5, p. 1047.]

41-3922. TAXATION -- PENALTY FOR FAILURE TO FILE. (1) Each organization offering a managed care plan for which a certificate of authority is required under this chapter shall be subject to taxation as provided in chapter 4, title 41, Idaho Code.

(2) Any managed care organization failing to file any documents required to be filed with the director by this chapter shall be liable to a fine of twenty-five dollars ($25.00) for each day of delinquency. As applicable, the director shall suspend or revoke the certificate of authority of a delinquent managed care organization until the document is filed and the fine, if any, is fully paid.

[(41-3922), added 1974, ch. 177, sec. 28, p. 1444; am. 1978, ch. 9, sec. 2, p. 17; am. 1982, ch. 252, sec. 2, p. 644; am. and redesig. 1997, ch. 204, sec. 25, p. 596.]

41-3923. COVERAGE OF ADOPTED NEWBORN CHILDREN -- COVERAGE OF MATERNITY AND COMPLICATIONS OF PREGNANCY. (1) Any contract delivered or issued for delivery in this state by an organization offering a managed care plan for which a certificate of authority is required, which provides coverage for injury or sickness for newborn dependent children of the members of the covered group, shall provide such coverage for such newborn children and infants, including adopted newborn children that are placed with the adoptive member of the covered group within sixty (60) days of the adopted child's date of birth, from and after the moment of birth. Coverage under the contract for an adopted newborn child placed with the adoptive member of the covered group more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. Coverage provided in accord with this section shall include, but not be limited to, coverage for congenital anomalies. For the purposes of this section, "child" means an individual who has not reached eighteen (18) years as of the date of the adoption or placement for adoption. For the purposes of this section, "placed" shall mean physical placement in the care of the adoptive member of the covered group, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive member of the covered group signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of this subsection (1) as to a child placed for adoption with a member of the covered group continues

in the same manner as it would with respect to a naturally born child of the member of the covered group until the first to occur of the following events:

(a) Date the child is removed permanently from that placement and the legal obligation terminates; or

(b) The date the member of the covered group rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

(2) The managed care organization shall not restrict coverage under a health care contract of any dependent child adopted by a member, or placed with a member for adoption, solely on the basis of a preexisting condition of the child at the time the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the member is eligible for coverage under the plan.

(3) Any new or renewing group disability insurance contract or blanket disability insurance contract delivered or issued for delivery in this state shall provide that an unmarried child under the age of twenty-five (25) years and who receives more than one-half (1/2) of his financial support from the parent shall be permitted to remain on the parent's or parents' contract. Further, any unmarried child of any age who is medically certified as disabled and financially dependent upon the parent is permitted to remain on the parent's or parents' contract.

(4) No health care contract which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, copayments, or coinsurance provisions as to involuntary complications of pregnancy, unless such provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in such plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery; however, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan.

Where a plan which provides or arranges direct health care services for its members contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from prenatal care and delivery. However, expenses resulting from any delivery in excess of the deductible amount shall be treated as expenses for any other illness under the plan. If the pregnancy is interrupted, the maternity deductible charged for prenatal care and delivery shall be based on the value of the medical services received, providing that it is never more than two-thirds (2/3) of the plan's maternity deductible.

This section shall apply to all health care contracts except any group health care contracts made subject to an applicable collective-bargaining agreement in effect before January 1, 1977.

For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All health care contracts subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1977, shall be con-

strued to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

(5) From and after January 1, 1998, no policy of disability insurance which provides medical expense maternity benefits shall restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that would be in conflict with the newborns' and mothers' health protection act of 1996.

[(41-3923) added 1976, ch. 113, sec. 4, p. 446; am. 1993, ch. 305, sec. 4, p. 1132; am. 1994, ch. 365, sec. 8, p. 1160; am. and redesig. 1997, ch. 204, sec. 26, p. 597; am. 1997, ch. 321, sec. 5, p. 955; am. 2009, ch. 125, sec. 5, p. 395.]

41-3924. LIMITATION OF BENEFITS FOR ELECTIVE ABORTIONS. All policies, contracts, plans or certificates delivered, issued for delivery or renewed in this state by an organization offering a managed care plan for which a certificate of authority is required shall exclude coverage for elective abortions. Such exclusion may be waived by endorsement and the payment of a premium therefor. Availability of such coverage shall be at the option of the contractor. For purposes of this section, an "elective abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

[(41-3924), added 1983, ch. 94, sec. 4, p. 207; am. and redesig. 1997, ch. 204, sec. 27, p. 598.]

41-3925. SERVICES PROVIDED BY GOVERNMENTAL ENTITIES. (1) From and after July 1, 1990, no contract shall be issued in Idaho by an organization offering a managed care plan for which a certificate of authority is required which excludes from coverage services rendered the member while a resident in an Idaho state institution, provided the services to the member would be covered by the contract if rendered to him outside an Idaho state institution.

(2) From and after July 1, 1990, no contract issued by an organization offering a managed care plan for which a certificate of authority is required may contain any provision denying or reducing benefits otherwise provided under the policy for the reason that the person insured is receiving health or mental health care or developmental services provided by the department of health and welfare, whether or not the department of health and welfare bases its charges for such services on the recipient's ability to pay. Provided, nothing in this section shall prevent the issuance of a contract which excludes or reduces benefits where the charge level or amount of the charge levied by a governmental entity for such services would vary or be affected in any way by the existence of coverage under the managed care plan.

[(41-3925), added 1990, ch. 300, sec. 4, p. 829; am. and redesig. 1997, ch. 204, sec. 28, p. 599.]

41-3926. MAMMOGRAPHY COVERAGE. (1) From and after July 1, 1992, all policies, contracts, plans or certificates issued by an organization offering a managed care plan which provide coverage for the surgical procedure known as a mastectomy which are delivered, issued for delivery, continued or renewed in this state shall provide minimum mammography examination or

equivalent examination coverage. Such coverage shall include at least the following benefits:

(a) One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.

(b) A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.

(c) A mammogram every year for any woman who is fifty (50) years of age or older.

(d) A mammogram for any woman desiring a mammogram for medical cause.

Such coverage shall not exceed the cost of the examination.

(2) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(3) Nothing in this section shall apply to specified accident, specified disease, hospital indemnity, medicare supplement, long-term care or other limited benefit health insurance policies.

[(41-3926), added 1992, ch. 132, sec. 4, p. 415; am. 1993, ch. 113, sec. 4, p. 290; am. and redesig. 1997, ch. 204, sec. 29, p. 599.]

41-3927. HEALTH CARE PROVIDERS -- PARTICIPATION BY ANY QUALIFIED, WILLING PROVIDER -- CONTRACTS -- GRIEVANCE PROCEDURE. (1) Any managed care organization issuing benefits pursuant to the provisions of this chapter shall be ready and willing at all times to enter into care provider service agreements with all qualified providers of the category or categories which are necessary to provide the health care services covered by an organization if the health care providers: are qualified under the laws of the state of Idaho, desire to become participant providers of the organization, meet the requirements of the organization, and practice within the general area served by the organization.

(2) Nothing in this section shall preclude an organization from refusing to contract with a provider who is unqualified or who does not meet the terms and conditions of the organization's participating provider contract or from terminating or refusing to renew the contract of a health care provider who is unqualified or who does not comply with, or who refuses to comply with, the terms and conditions of the participating provider contract including, but not limited to, practice standards and quality requirements. The contract shall provide for written notice to the participating health care provider setting forth any breach of contract for which the organization proposes that the contract be terminated or not renewed and shall provide for a reasonable period of time for the participating health care provider to cure such breach prior to termination or nonrenewal. If the breach has not been cured within such period of time the contract may be terminated or not renewed. Provided however, that if the breach of contract for which the organization proposes that the contract be terminated or not renewed is a willful breach, fraud or a breach which poses an immediate danger to the public health or safety, the contract may be terminated or not renewed immediately.

(3) Every managed care organization issuing benefits pursuant to this chapter shall establish a grievance system for providers. Such grievance system shall provide for arbitration according to chapter 9, title 7, Idaho Code, or for such other system which provides reasonable due process provi-

sions for the resolution of grievances and the protection of the rights of the parties.

(4) No managed care organization may require as an element of any provider contract that any person agree:

(a) To deny a member access to services not covered by the managed care plan if the member is informed that he will be responsible to pay for the noncovered services and the member nonetheless desires to obtain such services;

(b) To refrain from treating a member even at that member's request and expense if the provider had been, but is no longer, a contracting provider under the managed care plan and the provider has notified the member that the provider is no longer a contracting provider under the managed care plan;

(c) To the unnegotiated adjustment by the managed care organization of the provider's contractual reimbursement rate to equal the lowest reimbursement rate the provider has agreed to charge any other payor;

(d) To a requirement that the provider adjust, or enter into negotiations to adjust, his or her charges to the managed care organization if the provider agrees to charge another payor lower rates; or

(e) To a requirement that the provider disclose his or her contractual reimbursement rates from other payors.

(5) A managed care organization shall not refuse to contract with or compensate for covered services an otherwise eligible provider or nonparticipating provider solely because the provider has in good faith communicated with one (1) or more current, former, or prospective patient regarding the provisions, terms or requirements of the organization's products as they relate to the needs of the provider's patients.

(6) As part of a provider contract, a managed care organization may require a provider to indemnify and hold harmless the managed care organization under certain circumstances so long as the managed care organization also agrees to indemnify and hold harmless the provider under comparable circumstances.

(7) On request and within a reasonable time, a managed care organization shall make available to any party to a provider contract any documents referred to or adopted by reference in the contract except for information which is proprietary or a trade secret or confidential personnel records.

(8) A managed care organization shall permit a contracting provider who is practicing in conformity with community standards to advocate for his patient without being subject to termination or penalty for the sole reason of such advocacy.

(9) Subsections (1) and (2) of this section shall apply to provider participation contracts entered into after July 1, 1994.

[(41-3927), added 1994, ch. 275, sec. 3, p. 855; am. and redesig. 1997, ch. 204, sec. 30, p. 600; am. 1998, ch. 422, sec. 1, p. 1332.]

41-3928. INCENTIVES TO WITHHOLD CARE PROHIBITED. (1) No managed care organization shall offer a provider and no contract between a managed care organization and a provider shall contain any incentive plan that includes a specific payment made, in any type or form, to the provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered by the health care contract and provided with respect to a specific member or group of members with similar medical conditions.

(2) Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are not tied to specific medical decisions involving specific members or groups of members with similar medical conditions.

[41-3928, added 1997, ch. 204, sec. 31, p. 601.]

41-3930. UTILIZATION MANAGEMENT PROGRAM REQUIREMENTS. (1) All managed care organizations performing utilization management or contracting with third parties for the performance of utilization management shall:

(a) Adopt utilization management criteria based on sound patient care and scientific principles developed in cooperation with licensed physicians and other providers as deemed appropriate by the managed care organization. Such criteria shall be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis;

(b) Adopt procedures for a timely review by a licensed physician, peer provider or peer review panel when a claim has been denied as not medically necessary or as experimental. The procedure shall provide for a written statement of the reasons the service was denied and transmittal of that information to the appropriate provider for inclusion in the member's permanent medical record;

(c) Upon enrollment, require members to provide written authorization for the release of medical information to the managed care organization;

(d) Adopt procedures which protect the confidentiality of patient health records. Such procedures may permit a managed care organization to record a telephone conversation in the course of requesting patient medical information only if it complies with existing state and federal laws and the other party to the conversation is notified by voice message that he is being recorded. Upon written request and within a reasonable time, a copy of such recordings shall be provided to the other party to the conversation if the recorded conversation becomes an issue in a formal grievance procedure, and the other party agrees to reimburse the managed care organization for reasonable costs associated with providing the requested copy.

(2) If emergency services are offered, no managed care organization shall require prior authorization for emergency services. In addition, a managed care organization shall respond to member or provider requests for prior authorization of a nonemergency service within two (2) business days after complete member medical information is provided to the managed care organization unless exceptional circumstances warrant a longer period to evaluate a request. Qualified medical personnel shall be available during normal business hours for telephone responses to inquiries about medical necessity, including certification of continued length of stay.

(3) When prior approval for a covered service is required of and obtained by or on behalf of a member, the approval shall be final and may not be rescinded by the managed care organization after the covered service has been provided except in cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits or if the member for whom the prior approval was granted is not enrolled at the time the covered service was provided.

[41-3930, added 1997, ch. 204, sec. 33, p. 605.]

41-3931. PARTICIPATION IN IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION. (1) Each organization offering a managed care plan for which a certificate of authority is required under this chapter shall, as a condition of its authority to offer managed care plans in this state, be a member insurer of the Idaho life and health insurance guaranty association established under chapter 43, title 41, Idaho Code.

(2) The director may take such actions and promulgate such rules as may be necessary to effectuate the provisions of this section.

[41-3931, added 1997, ch. 204, sec. 34, p. 606; am. 2000, ch. 371, sec. 2, p. 1225.]

41-3932. EXEMPTIONS FROM APPLICATION OF CHAPTER. This chapter shall not apply to managed care programs operated under contract with the federal government under title XVIII of the federal social security act, as amended (medicare), or under contract with a plan otherwise exempt from operation of this chapter pursuant to the employee retirement income security act of 1974, as amended (ERISA). This chapter shall not apply to programs administered by the department of health and welfare under contract with the department of health and welfare under title XIX of the federal social security act, as amended (medicaid) or under programs administered by the department of health and welfare substance use disorder bureau or its contracted managed care organization.

[41-3932, added 1997, ch. 204, sec. 35, p. 606; am. 2008, ch. 317, sec. 1, p. 879.]

41-3940. PREEXISTING CONDITIONS. A general managed care plan shall comply with the following provisions:

(1) A general managed care plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A general managed care plan shall not define a preexisting condition more restrictively than a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

(2) Genetic information shall not be considered as a condition described in subsection (1) of this section in the absence of a diagnosis of the condition related to such information.

(3) A managed care organization that does not use preexisting condition limitations in any of its general managed care plans may impose an affiliation period. "Affiliation period" means a period of time not to exceed sixty (60) days for new entrants and not to exceed ninety (90) days for late enrollees during which no premiums shall be collected and coverage issued shall not become effective. Such period shall begin on the enrollment date. This subsection does not preclude application of any waiting period applicable to all new enrollees under the general managed care plan, provided that any carrier-imposed waiting period is no longer than sixty (60) days and is used in lieu of a preexisting condition exclusion. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

[41-3940, added 1997, ch. 321, sec. 6, p. 957.]