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18.01.26 - Rule to Implement the Managed Care Reform Act

IDAPA 18
TITLE 01
CHAPTER 26

18.01.26 - RULE TO IMPLEMENT THE MANAGED CARE REFORM ACT

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Chapter 39, Title 41, Idaho Code. (7-1-98)

001. TITLE AND SCOPE.

01. Title. This rule shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18.01.26, "Rule to Implement the Managed Care Reform Act." (7-1-98)

02. Scope. The Act and this Rule are intended to define procedures to be followed in establishing and operating a Managed Care Organization; to define how certain of the powers of the Managed Care Organization shall be exercised; to define certain required reserves or liabilities; to establish requirements of certain reports and general disclosures to be furnished to the Director; and to establish rules pertaining to an organized system of health care providers, or those providers who willingly accept referrals through the managed care organization. (7-1-98)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost at this agency. (7-1-98)

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by the provisions of IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General." (7-1-98)

004. DEFINITIONS.

01. The Act. All terms defined in the Act which are used in this rule shall have the same meaning as used in the Act. (7-1-98)

02. Balance Billing. An organized system of health care providers and providers who accept referrals from the Managed Care Organization are prohibited from balance billing individuals. Balance billing refers to the practice whereby a provider bills an individual covered under the benefit plan for the difference between the amount the provider normally charges for a service and the amount the plan, policy, or contract recognizes as the allowable charge or negotiated price for the service delivered. (7-1-98)

03. Director. The term, Director, as referred to in this rule, shall mean the Director of the Department of Insurance, State of Idaho. NOTE: Senate Bill No. 1294, effective July 1, 1974, created the position of Director of the Department of Insurance to be the chief executive officer of that department and to assume the duties of the previous Commissioner of Insurance. (7-1-98)

04. MCO. Managed Care Organizations shall be abbreviated to MCO in this rule. (7-1-98)

05. MCO Provider. MCO provider means any provider owned, managed, employed by, or under contract with an MCO to provide health care services to MCO members. An MCO provider includes a physician, hospital, or other person licensed or otherwise authorized to furnish health care services. (7-1-98)

005. -- 010. (RESERVED)

011. APPLICATION FOR CERTIFICATE OF AUTHORITY.

01. Certificate of Authority Required. Any person offering a managed care plan on a predetermined and prepaid basis is transacting the business of insurance and must be authorized under a Certificate of Authority

issued by the Director of Insurance. (7-1-98)

02. Availability of Forms. Application forms will be furnished by the Director on the request of the MCO. (7-1-98)

03. Application Requirements. The application for a Certificate of Authority will include the additional affidavits, statements, and other information as enumerated in Idaho Code, Sections 41-319, 41-3904, 41-3905, and 41-3906. After receiving these completed documents, the Director has the authority to request any supplemental information he deems necessary before final approval or disapproval is given. (7-1-98)

04. Capital Surplus and Deposit Requirements. In accordance with Idaho Code, Sections 41-3905(8) and 41-3905(9), a managed care organization having a valid Idaho certificate of authority to transact insurance as a health maintenance organization on or before July 1, 1997, or a managed care organization issued a certificate of authority after July 1, 1997, may be allowed by the Director of the Department of Insurance a period of up to three years to comply with the capital, surplus, and deposit requirements of Idaho Code, Sections 41-313 and 41-316 or 41-316A. (7-1-98)

a. The Director has established the following minimum increases in capital fund requirements as per Idaho Code, Section 41-3905(8), based on the number of enrolled members:

Enrolled Members	Capital Funds
0-100	200,000
101-300	300,000
301-500	400,000
501-700	500,000
701-1,000	1,000,000
1,001-2,000	1,500,000
2,001-3,000	2,000,000

(7-1-98)

b. In no event shall the organization's capital funds be less than the following:

One year after the organization becomes subject to Title 41, Chapter 39, as amended effective July 1, 1997:	$1,000,000
Two years after the date the organization becomes subject to Title 41, Chapter 39, as amended effective July 1, 1997:	$1,500,000
Three years after the date the organization becomes subject to Title 41, chapter 39, as amended effective July 1, 1997:	$2,000,000

(7-1-98)

c. Immediately upon becoming subject to Title 41, Chapter 39, Idaho Code, as amended effective July 1, 1997, the managed care organization's minimum statutory deposit requirements shall be calculated as fifty percent (50%) of the amount of the organization's Capital funds as calculated above up to a maximum of one million dollars ($1,000,000), but shall not be less than two hundred thousand dollars ($200,000). The amount of the deposit so held by the Department shall be adjusted based on the organization's December 31st and June 30th financial statement filings each year. In no event will the minimum required statutory deposit amount be reduced. Upon notification by the department of the necessary increase in the deposit amount, the organization will have no more than thirty (30) days to come into compliance with the required amount. Failure to increase the deposit as required will subject the

organization to suspension or revocation of its certificate of authority pursuant to Section 41-326, Idaho Code. (7-1-98)

012. SOLICITATION PRIOR TO ISSUANCE OF CERTIFICATE OF AUTHORITY.

01. Permission for Solicitation Required. In accordance with Section 4, paragraph (2) of the Act, a proposed MCO, after filing its application for a Certificate of Authority, may request permission from the Director to inform potential enrollees concerning its proposed managed care services. (7-1-98)

02. Solicitation Materials. Before contacting potential enrollees or subscribers, the proposed MCO shall submit its request for permission to the Director in writing, with copies of brochures, advertising or solicitation materials, sales talks or any other procedures or methods to be used. (7-1-98)

03. Methods of Solicitation. Advertising and solicitation materials used by a proposed MCO must meet the following minimum requirements: (7-1-98)

a. The prospective enrollee shall clearly be advised that: (7-1-98)

i. The proposed MCO is not as yet authorized to offer health care services in this state; (7-1-98)

ii. Coverage for health care services is not being provided at the time of the solicitation; (7-1-98)

iii. The solicitation is not a guarantee that any services will be provided at a future date. (7-1-98)

b. The format and content of any material offered shall be in conformity with the MCO Act. Such material shall contain but not be limited to the following information: (7-1-98)

i. Complete description of the proposed MCO services and other benefits to which the enrollee would be entitled; (7-1-98)

ii. The location of all facilities, the hours of operation, and the services which would be provided in each facility; (7-1-98)

iii. The predetermined periodic rate of payment for the proposed services; (7-1-98)

iv. All exclusions and limitations on the proposed services, including any copayment feature, and all restrictions relating to pre-existing conditions. (7-1-98)

c. No person shall solicit enrollment or inform prospective enrollees concerning proposed MCO services unless compensated solely as a salaried employee of the proposed MCO. (7-1-98)

013. ANNUAL DISCLOSURE, FILING WITH DIRECTOR.

The annual disclosure material required to be filed with the Director pursuant to Section 41-3914(3), Idaho Code, shall be filed with the reports to the Director on or before March 1 each year. (7-1-98)

014. ANNUAL REPORT TO THE DIRECTOR.

In accordance with Sections 41-3910 and 41-335, Idaho Code, every managed care organization shall annually on or before the first day of March, file with the Director a full and true statement of its financial condition, transactions and affairs as of the preceding December 31. Unless otherwise required by the Director, the statement is to be prepared in accordance with the annual statement instructions and the accounting practices and procedures manual adopted by the National Association of Insurance Commissioners (NAIC) and is to be submitted on the NAIC annual convention blank form. The managed care organization shall also file its annual audited financial report in accordance with IDAPA 18.01.62, "Annual Audited Financial Reports." (7-1-98)

015. PERSONNEL AND FACILITIES LISTING REQUIRED.

01. Current Listing Required. The MCO shall at all times keep a current list of all personnel,

providers and facilities employed, retained or under contract to furnish health care services to enrollees. This list shall be available to the Director at his request. (7-1-98)

02. Allowable Expense -- No Balance Billing. No MCO provider or other provider accepting a referral from an MCO, who treats or provides services to an individual covered by the MCO, shall charge to or collect from any member or other beneficiary any amount in excess of that amount of compensation determined or allowed for a particular service by the MCO or by the administrator for the MCO. Nothing in this section shall be construed to prevent the collection of any copayments, coinsurance, or deductibles allowed for in the plan design. (7-1-98)

03. Procedures for Basic Care and Referrals. The MCO shall provide basic health care to enrollees through an organized system of health care providers. In plans in which referrals to specialty physicians and ancillary services are required, the MCO provider or the MCO shall initiate the referrals. The MCO shall inform its providers of their responsibility to provide written referrals and any specific procedures that must be followed in providing referrals, including prohibition of balance billing. (7-1-98)

04. Health Care Services to Be Accessible. The MCO, either directly or through its organized system of health care providers, shall arrange for covered health care services, including referrals to providers within the organized system of health care providers and noncontracting providers, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted practice parameters. (7-1-98)

05. Out of Network Services. In the case of provider care which is delivered outside of the organized system of health care providers or defined referral system, the MCO must alert those covered under health benefit plans to the fact that providers which are not MCO providers, or have not accepted written referrals, may balance bill the customer for amounts above the MCO's maximum allowance. Consumers should be encouraged to discuss the issue with their providers (7-1-98)

016. SEVERABILITY CLAUSE.
If any provision of this rule, or the application thereof to any person or circumstance, is held invalid, the remainder of the rule, or the applicability of such provision to other persons or circumstances, shall not be affected thereby. (7-1-98)

017. -- 999. (RESERVED)

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