IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

Product Review

Chapter 18.04.04 –The Managed Care Reform Act Rule

Who does this rule apply to?
This rule applies to managed care organizations.

What is the purpose of this rule?
The purpose of this rule implements the Managed Reform Act by defining and establishing operating procedures.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statute passed by the Idaho Legislature:

- 41-39, et seq., Idaho Code - Managed Care Reform

Who do I contact for more information on this rule?

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18.04.04 – THE MANAGED CARE REFORM ACT RULE

000. LEGAL AUTHORITY.
Title 41, Chapter 39, Idaho Code. (7-1-21)T

001. TITLE AND SCOPE.

01. Title. IDAPA 18.04.04, "The Managed Care Reform Act Rule." (7-1-21)T

02. Scope. The Act and this chapter define procedures to be followed in establishing and operating a Managed Care Organization. (7-1-21)T

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Balance Billing. 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. (7-1-21)T

02. MCO. Managed Care Organizations is abbreviated to MCO in this rule. (7-1-21)T

03. 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 authorized to furnish health care services. (7-1-21)T

011. APPLICATION FOR CERTIFICATE OF AUTHORITY.

01. Certificate of Authority. Any person offering a managed care plan on a predetermined and prepaid basis is transacting the business of insurance and needs to be authorized under a Certificate of Authority issued by the Director of Insurance. (7-1-21)T

02. Application Requirements. The application for a Certificate of Authority will include the 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 before final approval or disapproval is given. (7-1-21)T

03. Capital Surplus and Deposit Requirements. (7-1-21)T

a. The Director has established the following minimum capital fund requirements as per Section 41-3905(8), Idaho Code, 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

(7-1-21)T

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

One year after the organization becomes subject to the Act	$1,000,000
Two years after the date the organization becomes subject to the Act	$1,500,000
Three years after the date the organization becomes subject to the Act	$2,000,000

(7-1-21)T

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c. Immediately upon becoming subject to the Act, the MCO's minimum statutory deposit requirements is 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 not less than two hundred thousand dollars ($200,000). The amount of the deposit so held by the Department is adjusted based on the organization's December 31st and June 30th financial statement filings each year. In no event will the minimum prescribed 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 prescribed amount. Failure to increase the deposit as prescribed will subject the organization to suspension or revocation of its certificate of authority pursuant to Section 41-326, Idaho Code. (7-1-21)T

012. SOLICITATION PRIOR TO ISSUANCE OF CERTIFICATE OF AUTHORITY.

01. Permission for Solicitation Requisite. In accordance with Section 41-3904, Idaho Code, 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. (7-1-21)T

02. Solicitation Materials. Before contacting potential enrollees or subscribers, the proposed MCO will 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. (7-1-21)T

03. Methods of Solicitation. Advertising and solicitation materials used by a proposed MCO need to meet the following minimum requirements: (7-1-21)T

a. The prospective enrollee will clearly be advised that: (7-1-21)T

i. The proposed MCO is not as yet authorized to offer health care services in this state; (7-1-21)T

ii. Coverage for health care services is not being provided at the time of the solicitation; (7-1-21)T

iii. The solicitation is not a guarantee that any services will be provided at a future date. (7-1-21)T

b. The format and content of any material offered will conform with the MCO Act. Such material will contain but not be limited to the following information: (7-1-21)T

i. Complete description of the proposed MCO services and other benefits to which the enrollee would be entitled; (7-1-21)T

ii. The location of all facilities, the hours of operation, and the services which would be provided in each facility; (7-1-21)T

iii. The predetermined periodic rate of payment for the proposed services; (7-1-21)T

iv. All exclusions and limitations on the proposed services, including any copayment feature, and all restrictions relating to pre-existing conditions. (7-1-21)T

c. No person will solicit enrollment or inform prospective enrollees concerning proposed MCO services unless compensated solely as a salaried employee of the proposed MCO. (7-1-21)T

013. ANNUAL DISCLOSURE, FILING WITH DIRECTOR.

The annual disclosure material prescribed to be filed with the Director pursuant to Section 41-3914, Idaho Code, is filed with the reports to the Director on or before March 1 each year. (7-1-21)T

014. ANNUAL REPORT TO THE DIRECTOR.

In accordance with Sections 41-3910 and 41-335, Idaho Code, every managed care organization will 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 prescribed by the Director, the statement is to be

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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 will also file its annual audited financial report in accordance with IDAPA 18.07.04, "Annual Audited Financial Reports." (7-1-21)T

015. PERSONNEL AND FACILITIES LISTING.

01. Current Listing. The MCO will 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 is to be made available to the Director upon request. (7-1-21)T

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, may 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 prevents the collection of any copayments, coinsurance, or deductibles allowed for in the plan design. (7-1-21)T

03. Procedures for Basic Care and Referrals. The MCO will 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 prescribed, the MCO provider or the MCO will initiate the referrals. The MCO will inform its providers of their responsibility to provide written referrals and any specific procedures that need to be followed in providing referrals, including prohibition of balance billing. (7-1-21)T

04. Health Care Services to Be Accessible. The MCO, either directly or through its organized system of health care providers, will 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. (7-1-21)T

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 will 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 (7-1-21)T

016. -- 999. (RESERVED)

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