

IN THE SENATE

SENATE BILL NO. 1272

BY BROADSWORD

AN ACT

RELATING TO INSURANCE; AMENDING SECTIONS 41-1846 AND 41-3915, IDAHO CODE,
TO REQUIRE CERTAIN INSURERS AND ORGANIZATIONS TO PROVIDE COVERAGE
FOR CHEMOTHERAPY TREATMENT AS A MAJOR MEDICAL CLAIM; AND DECLARING AN
EMERGENCY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 41-1846, Idaho Code, be, and the same is hereby
amended to read as follows:

41-1846. HEALTH CARE POLICIES -- APPLICABILITY -- REQUIREMENT. (1) An
insurer offering a health care policy that does not meet the definition of a
managed care plan as provided in section 41-3903(15), Idaho Code:

(a) Must have the intent to render and the capability for rendering or
providing coverage for good quality health care services, which will
be and are readily available and accessible to its insureds both within
and outside the state of Idaho, and such services must be reasonably
responsive to the needs of insureds;

(b) When "emergency services" are provided, they shall be provided as
set forth in section 41-3903(7), Idaho Code, and shall not require prior
authorization;

(c) Shall include on its website and/or send annually to its
policyholders:

(i) 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;

(ii) Notification of any change in benefits; and

(iii) A description of all prior authorization review procedures
for health care services;

(d) Shall 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 insured's permanent medical record;

(e) When prior approval for a covered service is required of and
obtained by or on behalf of an insured, the approval for the specific
procedure shall be final and may not be rescinded after the covered
service has been provided except in cases of fraud, misrepresentation,
nonpayment of premium, exhaustion of benefits or if the insured for whom
the prior approval was granted is not enrolled at the time the covered
service was provided; ~~and~~

(f) Shall not offer a provider any incentive that includes a specific
payment made, in any type or form, to the provider as an inducement

1 to deny, reduce, limit, or delay specific, medically necessary, and
 2 appropriate services covered by the health care policy; and
 3 (g) Shall provide coverage for chemotherapy treatment, whether the
 4 form of administration be oral, intravenous or other, as a major medical
 5 claim.

6 (2) No health care provider shall require an insured to make additional
 7 payments for covered services under a policy subject to subsection (1) of
 8 this section, other than specified deductibles, copayments or coinsurance
 9 once a provider has agreed in writing to accept the insurer's reimbursement
 10 rate to provide a covered service.

11 SECTION 2. That Section 41-3915, Idaho Code, be, and the same is hereby
 12 amended to read as follows:

13 41-3915. HEALTH CARE CONTRACTS. (1) All health care contracts or other
 14 marketing documents describing health care services offered by any managed
 15 care organization shall contain:

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

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

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

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

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

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

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

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

44 (i) Grievance procedures;

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

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

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

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

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

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

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

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

17 (f) Shall provide coverage for chemotherapy treatment, whether the
18 form of administration be oral, intravenous or other, as a major medical
19 claim.

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

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

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

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

47 (7) No such contract form or amendment to an approved contract form
48 shall be issued unless it has been filed with the director. The contract
49 form or amendment shall become effective thirty (30) days after such filing
50 unless specifically disapproved by the director. Any such disapproval shall

1 be based on the requirements of section 41-3905, Idaho Code, or subsection
2 (1), (2), (4), (5) or (6) of this section.

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

9 SECTION 3. An emergency existing therefor, which emergency is hereby
10 declared to exist, this act shall be in full force and effect on and after its
11 passage and approval.