

**[Idaho Code Ann. § 41-3905.]**

Idaho Code Ann. § 41-3905. Qualifications for certificate of authority: Managed Care Reform

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.