HOUSE BILL NO. 384

INTRODUCED BY MCKENNEY

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING A DEMONSTRATION PROJECT THAT ALLOWS HEALTH INSURANCE ISSUERS TO OFFER A LIMITED COVERAGE INDIVIDUAL HEALTH BENEFIT PLAN OR A MANAGED CARE PLAN; PROVIDING THAT THE INSURER MUST SPECIFY CLEARLY WHICH STATE-REQUIRED BENEFITS OR COVERAGES ARE NOT INCLUDED IN THE OFFERED LIMITED COVERAGE INDIVIDUAL PLAN; AMENDING SECTIONS 33-22-301, 33-22-706, ~~33-30-102,~~ 33-30-1001, 33-31-111, 33-31-202, 33-31-301, 33-36-201, AND 33-36-205, MCA; AND PROVIDING AN EFFECTIVE DATE AND A TERMINATION DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Legislative intent -- purpose.** (1) It is the intent of the legislature to provide for a demonstration project to allow a health service corporation, a health maintenance organization, or a health insurer to test the feasibility of a product to extend health care benefits to uninsured residents of Montana.

(2) It is the purpose of a demonstration project to provide coverage for health care services not otherwise available to uninsured residents of Montana.

NEW SECTION. **Section 2. Limited coverage individual health benefit plan or managed care plan -- demonstration project -- CRITERIA -- RULEMAKING.** (1) The commissioner of insurance may approve a 12-month demonstration project that allows a health insurance issuer to offer a limited coverage individual health benefit plan or managed care plan. THE CRITERIA FOR APPROVAL OF A 12-MONTH DEMONSTRATION PROJECT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

(A) THE PLAN MUST INCLUDE SIGNIFICANT OUTPATIENT SERVICES AND MAY NOT CONSIST OF INPATIENT BENEFITS ONLY;

(B) THE PLAN MAY BE OFFERED ONLY TO RESIDENTS OF MONTANA WHO HAVE BEEN UNINSURED FOR 90 DAYS OR LONGER; AND

(C) THE COMMISSIONER MAY ADOPT RULES THAT DESCRIBE ADDITIONAL CRITERIA TO BE USED TO DETERMINE

APPROVAL OF DEMONSTRATION PROJECTS. ADDITIONAL CRITERIA MUST RELATE TO THE PURPOSE AS STATED IN [SECTION 1(2)].

(2) The health benefit plan or managed care plan must specify the health services that are included and must specifically list the health services that will be limited or not be covered from the partial list of state-required coverage in subsection (3). THE LIMITATIONS AND EXCLUSIONS OF THE PLAN MUST BE PROMINENTLY DISPLAYED ON THE APPLICATION AND ON THE OUTLINE OF COVERAGE REQUIRED BY 33-22-244.

(3) Subject to subsection (4), if specifically listed as a limitation or an exclusion of coverage in the proposal, a demonstration project may limit or exclude the following health services from its health benefit plan or managed care plan:

(a) coverage of a newborn, as provided in 33-22-301, 33-30-1001, and 33-31-301(3)(e), WHICH MAY BE SUBJECT ONLY TO THE SAME EXTENT OF THE LIMITATIONS AND EXCLUSIONS CONTAINED IN THE PARENT'S POLICY;

(b) coverage for severe mental illness, as provided in 33-22-706;

(c) coverage for mental health services, as provided in 33-31-301(3)(g)(i);

(d) benefits for emergency services, as provided in 33-36-201 and 33-36-205;

(e) coverage for certain basic health care services described in 33-31-102(2)(b) and (2)(h)(v); or

(f) services provided by a specific category of licensed health care practitioner to be provided to the covered person for a health-related condition in a health benefit plan or managed care plan, including services described in 33-22-125 and 33-30-1017.

(4) All health benefit plan and managed care plan demonstration projects are subject to the following provisions:

(a) the requirement that any plan that covers physical illness generally must cover severe mental illness in a way that is no less favorable than that level provided for other physical illness generally as required by federal law;

(b) the prohibition against discrimination in 49-2-309; ~~and~~

(c) except as provided in subsection (3)(d), the provisions in Title 33, chapter 36, regarding network adequacy and quality assurance; AND

(D) ALL OTHER APPLICABLE PROVISIONS OF TITLE 33, EXCEPT THOSE LISTED IN SUBSECTION (3).

(5) Upon a renewal request and approval by the insurance commissioner, a demonstration project may be renewed for additional 12-month increments for a maximum total of 5 years.

NEW SECTION. **Section 3. Requirements of demonstration project.** Any health insurance issuer that participates in the demonstration project must:

(1) collect health risk assessment information at enrollment and reenrollment, which must be collected without reference to an individual, must allow individuals to remain anonymous, and must be reported to the commissioner only in the aggregate; and

(2) collect information on any uncompensated care that was received by the covered person directly related to the exclusion of benefits under [section 2].

Section 4. Section 33-22-301, MCA, is amended to read:

"33-22-301. Coverage of newborn under disability policy. (1) ~~Each~~ Except as provided in [section 2], each policy of disability insurance or certificate issued must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons. However, ~~that~~ for newborn infants there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) ~~A~~ Except as provided in [section 2], a policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 5. Section 33-22-706, MCA, is amended to read:

"33-22-706. Coverage for severe mental illness -- definition. (1) ~~A~~ Except as provided in [section 2(3)] and subject to [section 2(4)], a policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of severe mental illness, as defined in subsection (6), that is no less favorable than that level provided for other physical illness generally. Benefits for treatment of severe mental illness may be subject to managed care provisions contained in the policy or certificate.

(2) Benefits provided pursuant to subsection (1) include but are not limited to:

(a) inpatient hospital services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication;

(e) services rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed physician; and

(f) services rendered by a licensed advanced practice registered nurse with prescriptive authority and specializing in mental health.

(3) Benefits provided pursuant to this section must be included when determining maximum lifetime benefits, copayments, and deductibles.

(4) (a) This section applies to health service benefits provided by:

(i) individual and group health and disability insurance;

(ii) individual and group hospital or medical expense insurance;

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation;

(v) health maintenance organizations; and

(vi) the comprehensive health association created by 33-22-1503.

(b) This section does not apply to the following coverages:

(i) blanket;

(ii) short-term travel;

(iii) accident only;

(iv) limited or specific disease;

(v) Title XVIII of the Social Security Act (medicare); or

(vi) any other similar coverage under state or federal government plans.

(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental illness, as defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.

(6) As used in this section, "severe mental illness" means the following disorders as defined by the American psychiatric association:

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism."

~~**Section 6.** Section 33-30-102, MCA, is amended to read:~~

~~**"33-30-102. Application of this chapter -- construction of other related laws.** (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: 33-2-1212; 33-3-307; 33-3-308; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111 and [section 2].~~

~~(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict, the provisions of this chapter prevail."~~

Section 6. Section 33-30-1001, MCA, is amended to read:

"33-30-1001. Newborn infants covered by insurance by health service corporation. ~~A~~ Except as provided in [section 2], a disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each policy must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 7. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36, except as provided in [section 2]; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) ~~Chapter~~ Except as provided in [section 2], Title 33, chapter 1, parts 12 and 13, ~~of this title,~~ 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations."

Section 8. Section 33-31-202, MCA, is amended to read:

"33-31-202. Issuance of certificate of authority. (1) The commissioner shall issue or deny a certificate

of authority to any person filing an application pursuant to 33-31-201 within 180 days after receipt of the application. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in 33-31-212 if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy.

(b) The health maintenance organization will effectively provide or arrange for the provision of basic health care services, except as provided in [section 2], on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments. This requirement does not apply to the physical or mental health care services provided by a health maintenance organization to a person receiving medicaid services under the Montana medicaid program as established in Title 53, chapter 6.

(c) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection with the services;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with 33-31-216; and

(vi) any additional information that the commissioner may reasonably require.

(d) The enrollees must be afforded an opportunity to participate in matters of policy and operation pursuant to 33-31-222.

(e) Nothing in the proposed method of operation, as shown by the information submitted pursuant to 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by the commissioner.

(2) The commissioner may deny a certificate of authority only if the requirements of 33-31-404 are complied with.

(3) The commissioner shall examine each health maintenance organization applying for an initial certificate of authority to do business in this state. In lieu of making an examination under this part of any health

maintenance organization domiciled in another state, the commissioner may accept an examination report on the organization prepared by the insurance department of the organization's state of domicile."

Section 9. Section 33-31-301, MCA, is amended to read:

"33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person ~~resident~~ residing in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is

given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) except as provided in [section 2], a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in 33-22-133;

(g) except as provided in [section 2], a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) ~~A~~ Except as provided in [section 2], a health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) ~~A~~ Except as provided in [section 2], a health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to

the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 10. Section 33-36-201, MCA, is amended to read:

"33-36-201. Network adequacy -- standards -- access plan required. (1) A health carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and types of providers to ensure that all services to covered persons are accessible without unreasonable delay. Sufficiency in number and type of provider is determined in accordance with the requirements of this section. ~~Covered~~ Except as provided in [section 2], covered persons must have access to emergency care 24 hours a day, 7 days a week. A health carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria may include but are not limited to:

(a) a ratio of specialty care providers to covered persons;

(b) a ratio of primary care providers to covered persons;

(c) geographic accessibility;

(d) waiting times for appointments with participating providers;

(e) hours of operation; or

(f) the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(2) Whenever a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the covered benefit were obtained from participating providers or shall make other arrangements acceptable to the department.

(3) The health carrier shall establish and maintain adequate provider networks to ensure reasonable proximity of participating providers to the businesses or personal residences of covered persons. In determining whether a health carrier has complied with this requirement, consideration must be given to the relative availability of health care providers in the service area under consideration.

(4) ~~A health carrier offering a managed care plan in this state on October 1, 1999, shall file with the department on October 1, 1999, an access plan complying with subsection (6) and the rules of the department.~~ A health carrier offering a managed care plan in this state ~~for the first time after October 1, 1999,~~ shall file with the department an access plan meeting the requirements of subsection (6) and the rules of the department before offering the managed care plan. A plan must be filed with the department in a manner and form complying with the rules of the department. A health carrier shall file any subsequent material changes in its access plan with the department within 30 days of implementation of the change.

(5) A health carrier may request the department to designate parts of its access plan as proprietary or competitive information, and when designated, that part may not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. A health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide a copy of the plan upon request.

(6) An access plan for each managed care plan offered in this state must describe or contain at least the following:

(a) a listing of the names and specialties of the health carrier's participating providers;

(b) the health carrier's procedures for making referrals within and outside its network;

(c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in the managed care plan;

(d) the health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(e) the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(f) the health carrier's method of informing covered persons of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(g) the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians and for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(h) the health carrier's process for enabling covered persons to change primary care professionals;

(i) the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and a participating provider or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and be transferred to other providers in a timely manner.

(j) any other information required by the department to determine compliance with this part and the rules implementing this part.

(7) The department shall ensure timely and expedited review and approval of the access plan and other requirements in this section."

Section 11. Section 33-36-205, MCA, is amended to read:

"33-36-205. Emergency services <u>-- exception</u>. (1) A health carrier offering a managed care plan shall provide or pay for emergency services screening and emergency services and may not require prior authorization for either of those services. If an emergency services screening determines that emergency services or emergency services of a particular type are unnecessary for a covered person, emergency services or emergency services of the type determined unnecessary by the screening need not be covered by the health carrier unless otherwise covered under the health benefit plan. However, if screening determines that emergency services or emergency services of a particular type are necessary, those services must be covered by the health carrier. A health carrier shall cover emergency services if the health carrier, acting through a participating provider or other authorized representative, has authorized the provision of emergency services.

(2) A health carrier shall provide or pay for emergency services obtained from a nonnetwork provider within the service area of a managed care plan and may not require prior authorization of those services if use of a participating provider would result in a delay that would worsen the medical condition of the covered person

or if a provision of federal, state, or local law requires the use of a specific provider.

(3) If a participating provider or other authorized representative of a health carrier authorizes emergency services, the health carrier may not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item or health care services furnished in reliance on approval unless the approval was based on a material misrepresentation about the covered person's medical condition made by the provider of emergency services.

(4) Coverage of emergency services is subject to applicable coinsurance, copayments, and deductibles.

(5) For postevaluation or poststabilization services required immediately after receipt of emergency services, a health carrier shall provide access to an authorized representative 24 hours a day, 7 days a week, to facilitate review.

(6) The provisions of this section do not apply to a limited coverage individual managed care plan as provided in [sections 1 through 3]."

NEW SECTION. **Section 12. Codification instruction.** [Sections 1 through 3] are intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [sections 1 through 3].

NEW SECTION. **Section 13. Effective date.** [This act] is effective July 1, 2003.

NEW SECTION. **Section 14. Termination.** [This act] terminates June 30, 2009.

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