**02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**031 BUREAU OF INSURANCE**

**Chapter 191: HEALTH MAINTENANCE ORGANIZATIONS**

**Table of Contents**

Section 1. Purpose

Section 2. Authority

Section 3. Applicability and Scope

Section 4. Effective Date *(Repealed)*

Section 5. Definitions

Section 6. Application Submission Requirements

Section 7. Financial Standards

Section 8. Solicitation *(Repealed)*

Section 9. Requirements For Evidence of Coverage

Section 10. Maintenance and Access to Records

Section 11. Subcontracting

Section 12. Effective Date

**Section 1. Purpose**

 This rule clarifies application submission requirements for applicants seeking a health maintenance organization (HMO) certificate of authority, includingstandards for HMOs set forth in Chapter 56 which do not appear in 24-A M.R.S. §4203(3). It also subjects HMOs to other standards consistent with the requirements of Title 24-A Chapter 56 and 56-A.

**Section 2. Authority**

 This rule is adopted by the Superintendent pursuant to 24-A M.R.S. §§ 212, 4202-A(1), 4218, 4222-A and 4309.

**Section 3. Applicability and Scope**

 This rule shall apply to all health maintenance organizations (HMOs) as defined by 24-A M.R.S. §4202-A(10), except that the Superintendent may waive or modify certain requirements for HMOs granted limited authority under 24-A M.R.S. §4202-A(10)(A) (for example, an HMO licensed to offer only Medicare Advantage plans) if the Superintendent determines that those requirements were intended to apply only to full-service HMOs.

 [Drafting Note: In addition to the requirements of this rule, HMOs are subject to the requirements of Title 24-A, Chapter 56, Chapter 56-A, and Bureau of Insurance Rule Chapter 850. Nonprofit Hospital or Medical Service Organizations as defined by 24 M.R.S. §2301 should also refer to Title 24 Chapter 19. HMOs should note that Title 24 and Title 24-A Chapter 56 incorporate by reference other chapters and sections of Title 24-A, and that this list of applicable rules and statutes may not be comprehensive and is subject to change.]

All group policies and certificates and individual contracts written, issued, or renewed in this State on or after January 1, 2018 shall conform with Section 9 of this rule. For purposes of this rule, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract or evidence of coverage.

**Section 4. Effective Date** *(Repealed)*

**Section 5. Definitions**

 For purposes of this rule, the definitions of 24-A M.R.S. §4202-A apply, unless the context indicates otherwise.

**Section 6. Application Submission Requirements**

 In addition to the requirements of 24-A M.R.S. §4203(3), an application for an HMO certificate of authority shall include the information and documents set forth in this section. All data submitted by an applicant to the Commissioner of the Department of Health and Human Services must also be submitted to the Superintendent.

[Drafting Note: Any request for confidential handling of specific portions of the application is subject to the confidentiality protocol established by the Superintendent.]

 A. **Certification**

 The certification required by 24-A M.R.S. §4203(3) must include a statement that the applicant is aware of the requirements of Title 24-A Chapter 56 and this rule and agrees to conform to those requirements and any other prospectively applicable enacted or adopted requirements of which it has notice or should have cause to notice.

 B. **HMOs Affiliated With Insurers**

 An insurer operating in this State under a current Certificate of Authority may directly or through a subsidiary or affiliate corporation or other business entity, organize and operate an HMO in this State. If such joint affiliation is effected and the HMO is controlled by, under common control with, or exerts control over such affiliate, these corporations and the HMO, if a distinct entity, shall be subject to the law applicable to insurance holding companies, including 24-A M.R.S. §222 and Bureau of Insurance Rule Chapter 180.

 C. **Power of Attorney and Agent for Service of Process**

 A power of attorney must be filed by all foreign applicants to the extent required by 24‑A M.R.S. §4203(3)(J). In addition, all foreign and domestic health maintenance organizations are subject to and must comply with the requirements of 24-A M.R.S. §421. At the time of application for a certificate of authority, the applicant shall appoint an agent for service of process and file the appointment with the Superintendent.

 D. **Organizational Structure and Operations**

 Applications must include:

 1) An organizational chart for the HMO setting out the position classifications of personnel responsible for various phases of health care delivery and administrative responsibility.

 2) Biographical sketches and independent third party reviews using the National Association of Insurance Commissioners (NAIC) form current at the time of application of the applicant’s directors and officers, or, if the applicant is an association or a society, its partners or members.

 3) Disclosure by all principal officers and directors of the HMO, in statements attested under oath, of any real or potential conflict of interest, including pertinent employment contracts, deferred compensation contracts or other pecuniary interests. Such disclosure shall extend to any provider under contract with the HMO to provide health care services who also has managerial or directorship responsibilities with the HMO that permit the provider to influence the HMO’s decision-making.

 4) A description of any physical treatment centers such as clinics or satellite medical facilities owned or leased by the HMO.

 E. **Financial Information**

 1) The financial feasibility plan required by 24-A M.R.S. §4203(3)(I) shall include:

a) Projected financial statements for a three year period, including at a minimum, a balance sheet and income statement.

b) A description of the anticipated working funds available for day-to-day operational expenses of the HMO.

c) Detailed enrollment projections including marketing pro forma operating result projections for the coming three-year period.

d) The proposed methodology for determining liabilities consistent with the requirements of 24-A M.R.S. §4204(5).

e) The proposed investment strategy consistent with the requirements of 24-A M.R.S. §4204(3-A).

 2) Financial statements filed shall conform with NAIC adopted standards current at the time of application.

 3) The applicant shall provide its NAIC group code. If the applicant is not affiliated with an NAIC-designated insurance group, the applicant shall provide financial information satisfactory to the Superintendent relating to its parent company or other controlling person and its affiliates.

 F. **Quality Assurance Plan**

 Applications must include a written quality assurance plan which meets the requirements of 24-A M.R.S. §§ 4203(3)(M) and 4204(2-A)(B).

 G. **Marketing Materials** *(Repealed)*

 H. **Point of Service Plans**

 Applicants seeking to offer a point-of-service plan to enrollees shall file all information necessary to demonstrate the plan’s consistency with the requirements of 24-A M.R.S. §4207-A.

 I. **Complaint System**

 Applicants must file a description of their complaint system which demonstrates consistency with the requirements of 24-A M.R.S. §4211 and the *Health Plan Improvement Act*, Chapter 56-A.

 J. *(Omitted intentionally)*

 K. **Contracts**

 1) Copies of the following contracts must be filed with the application:

 a) Any contracts with insurers, non-profit hospital or medical service corporations, the United States Government or any other organization for providing health care services or insuring or providing for the cost of such services.

 b) Any fidelity bonds, arrangements or agreements entered into for self-insurance to respond to claims for:

 i) malpractice;

 ii) employers liability; and

 iii) workers’ compensation.

 c) All property insurance policies covering owned medical facilities.

 2) The provider contract filing requirement of 24-A M.R.S. §4203(D) may be satisfied by filing template contracts and applicable subcontracts, along with all proposed material deviations from those templates.

**Section 7. Financial Standards**

 A. If an HMO is operated by a corporation which is chartered for divergent purposes, separate accounts shall be maintained respecting the HMO’s operations as distinguished from other business functions of the corporation.

B. An HMO shall maintain minimum surplus in an amount equal to the greater of:

1. One million dollars;
2. Two percent (2%) of the first $150 million of annual premium revenues as reported in the HMO’s most recent annual financial statement and one percent (1%) of the annual premium in excess of $150 million;
3. An amount equal to three (3) months’ uncovered health care expenditures as reported in the HMO’s most recent annual statement;
4. An amount equal to eight percent (8%) of the HMO’s annual health expenditures, except those paid on a capitated basis, as reported on the HMO’s most recent annual financial statement; or
5. An amount of Risk-Based Capital sufficient to avoid a Company Action Level Risk-Based Capital Event as defined in 24-A M.R.S. §6453.

**Section 8. Solicitation** *(Repealed)*

**Section 9. Requirements for Evidence of Coverage**

 Evidences of coverage, including group contracts, individual contracts and certificates, must be delivered or issued for delivery to enrollees or group contract holders not more than fifteen (15) days from the later of the effective date of coverage or the date on which the HMO is notified of enrollment, and must, in addition to the requirements of 24-A M.R.S. §4207, include:

 A. **Essential Information**

1) The name, address and telephone number of the HMO.

2) How to contact the HMO by telephone at no cost to the enrollee.

3) A description of the HMO’s service area, or reference to a separate document bearing this information.

4) Detailed information on how to obtain services during regular office hours.

5) Detailed information on how to obtain services after hours.

6) Detailed information on how to obtain emergency, urgent and specialty services.

7) Detailed information on how to obtain coverage for emergency and urgent care outside the service area.

8) *(Repealed)*

9) Detailed information about the availability of assistance regarding coverage, complaints, and appeals, including explanations of:

1. How to file a complaint or appeal, and a statement of the enrollee’s right to contact the Superintendent of Insurance for assistance at any time. The statement shall include the Superintendent’s telephone number and address.
2. How to obtain assistance from the Maine Consumer Assistance Program in order to understand the enrollee’s coverage or appeal rights. The statement shall include the Program’s telephone number and address.

10) How to select and change providers within the HMO’s provider network.

11) The processes in place for coordination and continuity of care.

12) A description of the medications and services covered and excluded under the contract, including a description of how a consumer may obtain a copy of the plan’s certificate of coverage and a copy of the complete formulary or a URL or URLs at which the most current certificate of coverage and prescription formulary may be accessed.

 B. **Eligibility Requirements**

 Explanations of coverage must clearly outline the conditions that must be met by enrollees and their eligible dependents to obtain and maintain coverage.

 C. **Claims Procedures**

1) Any required notice to the HMO.

2) If claim forms are required, how, when and where to obtain and submit them.

3) Any requirements for filing proper proofs of loss.

4) Any time limit for payment of claims.

5) Notice of any provisions for resolving disputed claims, including appeals and external review.

6) All policies providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under Section 9(C) does not affect or limit the payment of benefits otherwise payable under the policy.

 D. **Coordination of Benefits**

 Evidences of coverage may contain a provision for coordination of benefits, provided that such provision shall not relieve an HMO of its duty to provide or arrange for a covered health care service to an enrollee solely because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs. Coordination with Medicare is permitted under the same conditions and manner applicable to non-HMO plans and described in 24-A M.R.S. §§ 2844 and 2723-A.

 E. **Term of Coverage**

Evidences of coverage shall describe the time and date or occurrence upon which coverage takes effect.

 F. **Cancellation or Termination**

 The group or individual contract shall contain the conditions upon which cancellation, rescission or other termination may be affected by the HMO, the group contract holder or the enrollee.

 G. **Renewal**

 Evidences of coverage shall contain the conditions for, and any restrictions upon, the enrollee’s right to renew.

 H.-J. *(Repealed)*

 K. **Grace Period**

1) The group or individual contract shall provide for a grace period of not less than thirty days for the payment of any premium except the first, during which time the coverage shall remain in effect if payment is made during the grace period. The evidence of coverage shall include notice that a grace period exists under the group contract and that coverage continues in force during the grace period.

2) During the grace period:

a) The HMO shall remain liable for providing the services and benefits contracted for;

b) The contract holder shall remain liable for the payment of premium for coverage during the grace period; and

c) The enrollee shall remain liable for any copayments and deductibles.

1. If the premium is not paid during the grace period, and the HMO has given 10 days’ notice to the designated third party if one has been designated pursuant to Bureau of Insurance Rule 580, coverage is automatically terminated at the end of the grace period, subject to any right of reinstatement pursuant to 24-A M.R.S. §§ 2707-A or 2847-C. For group contracts the HMO shall provide at least 10 days’ notice to certificate holders prior to cancellation in a manner consistent with the requirements of 24-A M.R.S. §2809-A(1-A). Following the effective date of such termination, the HMO shall send the contract holder written notice advising that coverage has been terminated.

 L. **Conformity with State Law**

Evidences of coverage delivered or issued for delivery in this State shall include a provision stating that any provision not in conformity with Chapter 56 of Title 24-A, this rule or any other applicable law or regulation in this State shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable laws and regulations of this State.

M. **Covered Services**. A plan must provide basic health care services that include coverage for all state and federally mandated benefits, including any essential health benefits required for individual and small group plans under the federal *Affordable Care Act*. Mental health and substance use disorder services must be covered in all group and individual contracts in a manner consistent with state and federal mental health parity requirements.

[Drafting Note: When the 2017 amendments to this rule were adopted, the *Affordable Care Act* required coverage for the following essential health benefits: 1) Ambulatory patient services, 2) Emergency services, 3) Hospitalization, 4) Maternity and newborn care, 5) Mental health and substance use disorder services, including behavioral health treatment, 6) Prescription drugs, 7) Rehabilitative and habilitative services and devices, 8) Laboratory services, 9) Preventive and wellness services and chronic disease management, 10) Pediatric services, including oral and vision care.]

In addition to other state and federal requirements, and to the extent medically necessary, a plan must cover the following, subject to any applicable minimum benefit provisions.

1) Inpatient Hospital Services.

2) Preventive Services.

3) Routine Newborn Services must be made available under either the mother’s policy or the father’s policy, consistent with the requirements of 24-A M.R.S. §§ 4234-B and 4234-C.

[Drafting note: When the 2017 amendments to this rule were adopted, routine newborn services included: 1) Routine inpatient hospital nursery care for the newborn, 2) Routine inpatient hospital physician services for the newborn, 3) Vaccines and immunizations administered to the newborn prior to discharge, 4) Vitamins administered to the newborn prior to discharge, 5) Routine eye care administered to the newborn prior to discharge, 6) Metabolic screening administered to the newborn prior to discharge.]

4) Annual physical examinations for children and adults, which must include:

1. Gynecological examinations, when appropriate.
2. For children ages three to seventeen, periodic evaluation of physical and emotional status, a history, a complete physical examination, a developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards.

5) Prescription drugs must be covered, except that the HMO is not required to include a prescription drug benefit for large group plans if the employer has offered a separate prescription drug benefit.

6) If emergency care is required, ambulance transportation to the nearest contracted facility or to the nearest non-contracted facility capable of providing necessary care.

7) Home health care by an accredited agency under a written plan by a physician, or other licensed provider such as a Nurse Practitioner or Physician Assistant, working within the provider’s scope of practice, for a minimum of 90 visits per calendar year.

N. **Exclusions**

A plan may contain exclusions approved by the Superintendent that are not otherwise prohibited by state or federal law, rule, or regulation. Unless otherwise directed by the Superintendent, HMO plans may contain exclusions similar to exclusions permitted in non-HMO plans that provide Essential Healthcare Benefits in accordance with the *Affordable Care Act*.

 O. **Right to Examine Contract**

 An individual contract shall contain a provision stating that the enrollee may return the contract within ten (10) days of receiving it and receive a refund of the premium paid if the person is not satisfied with the contract for any reason. If the contract is returned to the HMO or to the agent through whom it was purchased, it is considered void from the effective date. However, if services are rendered or claims are paid for such person by the HMO during the ten-day examination period and the person returns the contract to receive a refund of the premium paid, the person shall be required to pay for such services. Contracts may impose reasonable requirements on enrollees for establishing the 10 day time frame for returning a purchased contract. This provision does not apply to individuals covered under a group contract issued to an employee group as defined by 24-A M.R.S. §2804 or a labor union group as defined in §2805.

**Section 10. Maintenance and Access to Records; Response to Inquiries**

 A. For the purposes of determining compliance with the law and applicable regulations, the Superintendent may as often as he or she deems advisable, examine the accounts, records, documents and transactions of an HMO and any person or entity under contract with the HMO either directly or indirectly.

 B. HMOs shall retain records of their affairs and transactions for a period of at least 6 years, and shall require any person or entity under contract with the HMO, either directly or indirectly, to retain records of their affairs and transactions relating to the HMO for a period of at least 6 years.

 C. HMOs shall respond to all lawful inquiries of the Superintendent that relate to resolution of consumer complaints within 14 days of receipt of the inquiry and to all other lawful inquiries of the Superintendent within 30 days of receipt.

**Section 11. Subcontracting**

 A. The execution of a subcontract by an HMO shall not relieve the HMO of its liability to any enrollee with whom it has contracted for the provision of services or for its responsibility for compliance with the law or applicable regulations. Services to enrollees shall not be delayed, reduced, denied or otherwise hindered because of the financial or contractual relationship between the HMO and a subcontractor.

 B. All subcontracts for the provision of services to enrollees shall incorporate the hold harmless requirements of 24-A M.R.S. §4204(6), and all applicable requirements of law and regulation.

 C. A contract between an HMO and a network administrator shall give the HMO the right, in the event of the administrator’s insolvency, to require assignment to the HMO of those provisions of network participating providers’ contracts addressing providers’ obligation to furnish covered services to the HMO.

 D. An HMO may not subcontract all responsibility for member grievance system operation or resolution to providers or networks under contract with the HMO for the provision of services to enrollees, and enrollees shall retain the right to pursue a grievance directly with the HMO.

**Section 12. Effective Date**

 The 2017 amendments to this rule are effective July 28, 2017.

STATUTORY AUTHORITY. 24-A M.R.S. §§ 212, 4202-A(1), 4218, 4222-A, 4309

EFFECTIVE DATE (as Chapter 190):

 September 1, 1976 - filed July 20, 1978 (78-58) under the *Administrative Procedure Act*

AMENDED (as Chapter 190):

 March 11, 1987 – filing 87-84

CHAPTER 190 REPEALED, REPLACED WITH CHAPTER 191:

 December 24, 1996 – filing 96-554

EFFECTIVE DATE (ELECTRONIC CONVERSION):

 January 14, 1997

AMENDED:

 July 28, 2017 – filing 2017-098 (Final adoption, major substantive)