MAINE STATE LEGISLATURE

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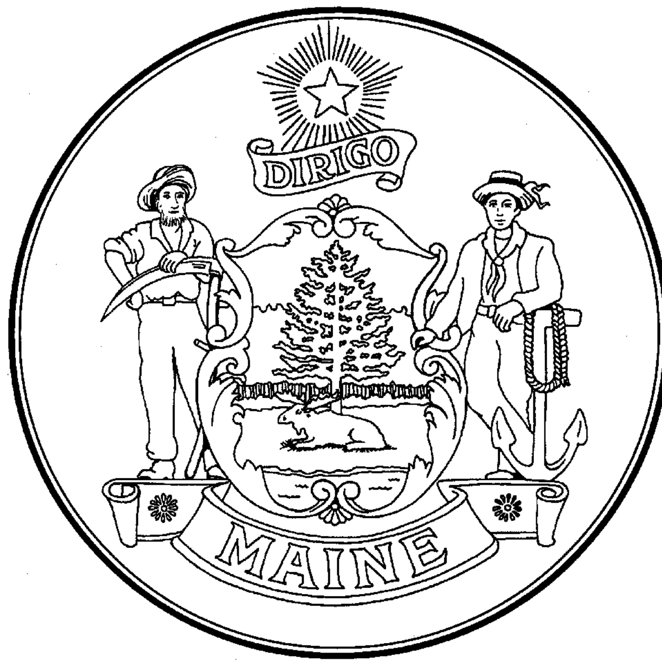

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ONE HUNDRED AND SIXTH LEGISLATURE

Legislative Document No. 1230

H. P. 786 House of Representatives, February 27, 1973
Referred to the Committee on State Government. Sent up for concurrence and ordered printed.

E. LOUISE LINCOLN, Clerk

Presented by Mr. Donaghy of Lubec.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-THREE

AN ACT Creating the Maine Health Maintenance Organization Act.

Be it enacted by the People of the State of Maine, as follows:

R. S., T. 24-A, c. 56, additional. Title 24-A of the Revised Statutes, as enacted by section 1 of chapter 132 of the public laws of 1969, is amended by adding a new chapter 56 to read as follows:

CHAPTER 56

HEALTH MAINTENANCE ORGANIZATION

§ 4201. Short title

This Act may be cited as the Health Maintenance Organization Act of 1973.

§ 4202. Definitions

As used in this chapter unless the context otherwise indicates the following words shall have the following meanings.

1. Basic health care services. "Basic health care services" shall mean health care services which an enrolled population might reasonably require in order to be maintained in good health, including as a minimum, emergency care, inpatient hospital and physician care and outpatient medical services.

2. Commissioner. "Commissioner" shall mean the Insurance Commissioner.

3. Enrollee. "Enrollee" shall mean an individual who has been enrolled in a health care plan.

4. Evidence of coverage. "Evidence of coverage" shall mean any certificate, agreement or contract issued to an enrollee setting out the coverage to which he is entitled.

5. Health care plan. "Health care plan" shall mean any arrangement whereby any person undertakes to provide, arrange for, pay for or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of such services, on a prepaid basis through insurance or otherwise.

6. Health care services. "Health care services" shall mean any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury.

7. Health maintenance organization. "Health maintenance organization" shall mean any person which undertakes to provide or arrange for one or more health care plans.

8. Insurance company. "Insurance company" and "insurer" shall mean any company defined in and authorized to act under chapters 5, 47, 51 or 55, or any company defined in and authorized to act under Title 24, chapter 19.

9. Person. "Person" shall mean any natural or artificial person including but not limited to individuals, partnerships, associations, trust or corporations.

10. Provider. "Provider" shall mean any physician, hospital or other person which is licensed or otherwise authorized in this State to furnish health care services.

§ 4203. Establishment of health maintenance organizations

1. Notwithstanding any law of this State to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. No person shall establish or operate a health maintenance organization in this State, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this Act. A foreign corporation may qualify under this Act, subject to its registration to do business in this State as a foreign corporation.

2. Every health maintenance organization as of the effective date of this Act shall submit an application for a certificate of authority under subsection 3 within 30 days of the effective date of this Act. Each such applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied under section 4204, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked.

3. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form pre-

scribed by the commissioner, and shall set forth or be accompanied by the following:

A. A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments thereto;

B. A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

C. A list of the names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation and the partners or members in the case of a partnership or association;

D. A copy of any contract made or to be made between any providers or persons listed in paragraph C and the applicant;

E. A statement generally describing the health maintenance organization, its health care plan or plans, facilities and personnel;

F. A copy of the form of evidence of coverage to be issued to the enrollees;

G. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

H. Financial statements showing the applicant's assets, liabilities and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this Act;

I. A description of the proposed method of marketing the plan, a financial plan which includes a 3-year projection of the initial operating results anticipated and a statement as to the sources of working capital as well as any other sources of funding;

J. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;

K. A statement reasonably describing the geographic area or areas to be served;

L. A description of the complaint procedures to be utilized as required under section 4212;

M. A description of the procedures and programs to be implemented to meet the quality of health care requirements in section 4204, subsection 1, paragraph B;

N. A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 4206, subsection 2;

O. Such other information as the commissioner may require to make the determinations required in section 4204.

4. A health maintenance organization shall, unless otherwise provided in this Act, file a notice describing any modification of the operation set out in the information required by this section. Such notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove within 30 days of filing, such modification shall be deemed approved.

5. The commissioner may promulgate rules and regulations exempting from any filing requirements of those items he deems unnecessary.

§ 4204. Issuance of certificate of authority

1. Procedure upon receipt of an application for issuance of a certificate of authority.

A. Upon receipt of an application for issuance of a certificate of authority, the commissioner forthwith shall transmit copies of such application and accompanying documents to the Commissioner of Health and Welfare.

B. The Commissioner of Health and Welfare shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:

(1) Has demonstrated the willingness and potential ability to assure that such health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility and continuity of service;

(2) Has arrangements, established in accordance with regulations promulgated by the Commissioner of Health and Welfare for an on-going quality of health care assurance program concerning health care processes and outcomes; and

(3) Has a procedure, established in accordance with regulations of the Commissioner of Health and Welfare, to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the Commissioner of Health and Welfare.

C. Within 10 days of receipt of the application for issuance of a certificate of authority, the Commissioner of Health and Welfare shall certify to the commissioner whether the proposed health maintenance organization meets the requirements of this section. If the Commissioner of Health and Welfare certifies that the health maintenance organization does not meet such requirements, he shall specify in what respects it is deficient.

2. The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to section 4203 within 20 days of receipt

of the certification from the Commissioner of Health and Welfare. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 4223 if the commissioner is satisfied that the following conditions are met:

A. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

B. The Commissioner of Health and Welfare certifies that the health maintenance organization's proposed plan of operation meets the requirements of this section;

C. The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments;

D. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees.

In making this determination, the commissioner may consider:

(1) The financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in connection therewith;

(2) The adequacy of working capital which shall not be less the $100,000;

(3) Any agreement with an insurer, a government or any other organization for insuring 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 plan;

(4) Any agreement with providers for the provision of health care services; and

(5) Any surety bond or deposit of cash or securities submitted in accordance with section 4214 as a guarantee that the obligations will be duly performed.

E. The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to section 4206;

F. Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 4203 or by independent investigation, is contrary to the public interest; and

G. Any deficiencies certified by the Commissioner of Health and Welfare have been corrected.

3. A certificate of authority shall be denied only after compliance with the requirements of section 4222.

§ 4205. Powers of health maintenance organizations

1. The powers of health maintenance organization include, but are not limited to the following:

A. The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

B. The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;

C. The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;

D. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

E. The contracting with an insurance company licensed in this State for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

F. The offering, in addition to basic health care services, of:

(1) Additional health care services;

(2) Indemnity benefits covering out-of-area or emergency services provided through insurers;

(3) Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers.

2. Approved powers.

A. A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in this section. The commissioner shall disapprove such exercise of power if in his opinion it would substantially and adversely affect the financial soundness of the health meaintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within 30 days of the filing, it shall be deemed approved.

B. The commissioner may promulgate rules and regulations exempting from the filing of this section those activities having a de minimis effect.

§ 4206. Governing body

1. The governing body of any health maintenance organization may include providers, other individuals, or both.

2. Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the

establishment of advisory panels, by the use of advisory referenda on major policy decisions or through the use of other mechanisms.

§ 4207. Fiduciary responsibilities

Any director, officer or partner of a health maintenance organization who receives, collects or disburses funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees.

§ 4208. Evidence of coverage and charges for health care services

1. Every enrollee residing in this State is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy whether by option or otherwise, the insurer shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

2. No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

3. An evidence of coverage shall contain:

A. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in section 4215; and

B. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

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

(2) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner information is available as to how services may be obtained; and

(4) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts or an indication whether the plan is contributory or noncontributory with respect to group certificates;

(5) A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

4. A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of this section unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance, in which event the filing and approval provisions of such laws shall apply.

5. No schedule of charges for enrollee coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until a copy of such schedule, or amendment thereto, has been filed with and approved by the commissioner.

6. Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. However, the charges shall not be excessive, inadequate or unfairly discriminatory. A certification, by a qualified actuary, to the appropriateness of the charges, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

7. The commissioner shall, within a reasonable period, approve any form and any schedule of charges if the requirements of this section are met. It shall be unlawful to issue such form or to use such schedule of charges until approved. If the commissioner disapproves such filing, he shall notify the filer. In the notice, the commissioner shall specify the reasons for his disapproval. A hearing will be granted within 10 days after a request in writing by the person filing. If the commissioner does not approve any form or schedule of charges within 30 days of the filing of such forms or charges, they shall be deemed approved.

8. The commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

§ 4209. Annual report

1. Every health maintenance organization shall annually, on or before the first day of June, file a report verified by at least 2 principal officers with the commissioner, with a copy to the Commissioner of Health and Welfare, covering the preceding calendar year.

2. Such report shall be on forms prescribed by the commissioner and shall include:

A. A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant;

B. Any material changes in the information submitted pursuant to section 4203;

C. The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year;

D. A summary of information compiled pursuant to section 4204 in such form as required by the Commissioner of Health and Welfare; and

E. Such other information relating to the performance of the health maintenance organization as is necessary to enable the commissioner to carry out his duties under this Act.

§ 4210. **Information to enrollees**

Every health maintenance organization shall annually provide to its enrollees:

1. The most recent annual statement of financial condition including a balance sheet and summary of receipts and disbursements;

2. A description of the organizational structure and operation of the health care plan and a summary of any material changes since the issuance of the last report;

3. A description of services and information as to where and how to secure them; and

4. A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

§ 4211. Open enrollment

1. After a health maintenance organization has been in operation 24 months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. A health maintenance organization may apply to the commissioner for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner shall approve or deny such application within 10 days of the receipt thereof from the health maintenance organization.

2. Health maintenance organizations providing or arranging for services exclusively on a group contract basis may limit the open enrollment provided for in this section to all members of the group or groups covered by such contracts.

§ 4212. Complaint system

1. Every health maintenance organization shall establish and maintain a complaint system which has been approved by the commissioner, after consultation with the Commissioner of Health and Welfare, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

2. Each health maintenance organization shall submit to the commissioner and the Commissioner of Health and Welfare an annual report in a form prescribed by the commissioner, after consultation with the Commissioner of Health and Welfare, which shall include:

A. A description of the procedures of such complaint system;

B. The total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed; and

C. The number, amount and disposition of malpractice claims settled during the year by the health maintenance organization and any of the providers used by it.

3. The health maintenance organization shall maintain records of written complaints filed with it concerning other than health care services and shall submit to the commissioner a summary report at such times and in such format as the commissioner may require. Such complaints involving other persons shall be referred to such persons with a copy to the commissioner.

4. The commissioner or the Commissioner of Health and Welfare may examine such complaint system.

§ 4213. Investments

With the exception of investments made in accordance with section 4205, subsection 1, paragraphs A and B and section 4205, subsection 2, the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner may permit.

§ 4214. Protection against insolvency

Each health maintenance organization shall furnish a surety bond in an amount satisfactory to the commissioner or deposit with the commissioner cash or securities acceptable to him in at least the same amount as a guarantee that the obligations to the enrollees will be performed. The commissioner may waive this requirement whenever satisfied that the assets of the organization or its contracts with insurers, governments or other organizations are sufficient to reasonably assure the performance of its obligations.

§ 4215. Prohibited practices

1. No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this Act:

A. A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

B. A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist;

C. An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

2. Sections 2151 to 2182 shall be construed to apply to health maintenance organizations, health care plans and evidences of coverage except to the extent that the commissioner determines that the nature of health maintenance organizations, health care plans and evidences of coverage render such sections clearly inappropriate.

3. An enrollee may not be cancelled or nonrenewed except for the failure to pay the charge for such coverage or for such other reasons as may be promulgated by the commissioner.

4. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts or literature any of the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

§ 4216. Regulation of agents

The commissioner may, after notice and hearing, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents. An agent means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment.

§ 4217. Powers of insurers

1. An insurance company licensed in this State, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under this Act. Notwithstanding any other law which may be inconsistent herewith, any 2 or more such insurance companies, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

2. Notwithstanding any provision of this Title, an insurer may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health care plan.

§ 4218. Examinations

1. The commissioner may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements pursuant to its health care plan as often as he deems it necessary for the protection of the interests of the people of this State but not less frequently than once every 3 years.

2. The Commissioner of Health and Welfare may make an examination concerning the quality of health care services of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements, pursuant to its health care plan as often as he deems it necessary for the protection of the interests of the people of this State but not less frequently than once every 3 years.

3. Every health maintenance organization and provider shall submit its books and records relating to the health care plan to such examinations and in every way facilitate them. For the purpose of examinations, the commissioner and the Commissioner of Health and Welfare may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

4. The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner or the Commissioner of Health and Welfare for whom the examination is being conducted.

5. In lieu of such examination, the commissioner or Commissioner of Health and Welfare may accept the report of an examination made by persons holding comparable office of another state.

§ 4219. Suspension or revocation of certificate of authority

1. The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this Act if he finds that any of the following conditions exist:

A. The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under section 4203, unless amendments to such submissions have been filed with and approved by the commissioner;

B. The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of section 4208;

C. The health care plan does not provide or arrange for basic health care services;

D. The Commissioner of Health and Welfare certifies to the commissioner that:

(1) The health maintenance organization does not meet the requirements of section 4204, subsection 1, paragraph B; or

(2) The health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan.

E. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

F. The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section 4206;

G. The health maintenance organization has failed to implement the complaint system required by section 4212 in a manner to reasonably resolve valid complaints;

H. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

I. The continued operation of the health maintenance organization would be hazardous to its enrollees;

J. The health maintenance organization has otherwise failed to substantially comply with this Act.

2. A certificate of authority shall be suspended or revoked only after compliance with the requirements of section 4222.

3. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

4. When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

§ 4220. Rehabilitation, liquidation or conservation of health maintenance organizations

Any rehabilitation, liquidation or conservation or a health maintenance organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the laws governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing him to rehabilitate, liquidate or conserve a health

maintenance organization when in his opinon the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State.

§ 4221. Regulations

The commissioner may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out this Act. Such rules and regulations shall be subject to review in accordance with sections 229 to 236.

§ 4222. Administrative procedures

1. When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and the Commissioner of Health and Welfare in writing specifically stating the grounds for denial, suspension or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

2. The Commissioner of Health and Welfare, or his designated representative, shall be in attendance at the hearing and shall participate in the proceedings. The recommendation and findings of the Commissioner of Health and Welfare with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension or revocation of a certificate of authority, shall be conclusive and binding upon the commissioner. After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the commissioner shall take action as is deemed advisable on written findings which shall be mailed to the health maintenance organization with a copy thereof to the Commissioner of Health and Welfare. The action of the commissioner and the recommendation and findings of the Commissioner of Health and Welfare shall be subject to review by the Superior Court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm or reverse the order of the commissioner in whole or in part.

§ 4223. Fees

1. Every health maintenance organization subject to this Act shall pay to the commissioner the following fees:

A. For filing an application for a certificate of authority or amendment thereto $500;

B. For filing each annual report, $50.

2. Fees charged under this section shall be distributed as follows: 50% to the commissioner and 50% to the Commissioner of Health and Welfare.

§ 4224. Penalties and enforcement

1. The commissioner may, in lieu of suspension or revocation of a certificate of authority under section 4219, levy an administrative penalty in an

amount not less than $100 nor more than $500, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

2. Any person who violates this Act shall be guilty of a misdemeanor and may be punished by a fine not to exceed $1,000 or by imprisonment for a period not exceeding 6 months, or by both.

3. If the commissioner or the Commissioner of Health and Welfare shall for any reason have cause to believe that any violation of this Act has occurred or is threatend, the commissioner or Commissioner of Health and Welfare may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner or the Commissioner of Health and Welfare may deem appropriate under the circumstances.

4. The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of this Act.

Within 10 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Act have occurred.

5. In the case of any violation under this Act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to this section, the commissioner may institute a proceeding to obtain injunctive relief or seeking other appropriate relief.

§ 4225. Statutory construction and relationship to other laws

1. Except as otherwise provided in this Act, provisions of the insurance law shall not be applicable to any health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurer licensed and regulated pursuant to the insurance laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this Act.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives shall not be construed to violate any provision of law relating to solicitation or advertising by health

professionals.

3. Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from provisions of law relating to the practice of medicine.

§ 4226. Filings and reports as public documents

All applications, filings and reports required under this Act shall be treated as public documents.

§ 4227. Confidentiality of medical information

Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

§ 4228. Commissioner of Health and Welfare's authority to contract

The Commissioner of Health and Welfare, in carrying out his obligations under sections 4204, subsection 1, paragraph B, 4218 and 4219, subsection 1, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the Commissioner of Health and Welfare.

STATEMENT OF FACT

Introductory comment.

The rising cost of health services in recent years has led government agencies, private organizations and legislative bodies to seek alternatives to the traditional medical delivery system which would provide improved health care and would provide that health care at a lower cost. The health maintenance organization is a concept which has received much attention as one means through which an improvement in delivery might be achieved.

Shortcomings of the existing health care delivery system.

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into 3 subareas: (a) In many areas of the State, the availability of health care in

terms of the quantity of manpower and facilities is inadequate; (b) even where physicians, nurses, clinics and hospitals do exist, they may lack **accessibility** due to poor location, poor management, lack of transportation, language or racial barriers, inconvenient hours, etc.; and (c) even if health care is available and accessible, it may not be continuous: that is, a single patient may not be treated as a person with a **continuing** or a variety of problems but rather as a single isolated health care problem incident. The problems of availability, accessibility and continuity, at least in part, have been attributed to the lack of **responsibility** vested in one person, group or organization to assure the delivery of health care.

A 2nd problem is the escalating cost of health care services. This stems from the limited supply of health care service facilities which is confronted by an expanded and fragmented financial mechanism and the consequent tremendous increase of demand for such services. This is the classic model for inflation. Traditional reimbursement of providers by the Federal Government, insurance plans and hospital and medical service corporations, because of the inherent difficulties involved, has been accompanied by uneven efforts toward effective cost review of control. Furthermore, services or facilities are often duplicated or used inefficiently. A basic cause of inflation and inefficiency rests with the improper structuring of incentives. Where no individual, group or organization is responsible for the use of more economical services and facilities, including those relating to preventive care, greater income is generated for providers by the more frequent use of services and facilities and by the use of the more expensive facilities and services available.

A 3rd problem is the quality of health care delivered. Throughout various parts of the State, the quality of health care can range from the very best to possibly inadequate. Generally speaking, there is no locus for quality assessments either as to health care processes or health care results. In the absence of a means to measure quality, it is virtually impossible to effectively design and implement programs to rectify defects.

This brief discussion in no way attempts to provide a comprehensive discussion of the problems of the health care delivery system in the State of Maine nor does it give adequate recognition to the strenuous efforts of many to improve the existing system. However, it does highlight some of the major problems prevailing today. Development of the health maintenance organization (HMO) concept offers one alternative means to help alleviate some of these problems. What then is an HMO?

Nature of the health maintenance organization.

A health maintenance organization may be described as an organization which brings together a comprehensive range of medical services in a single organization to assure a patient of convenient access to health care services. It furnishes needed services for a prepaid fixed fee paid by or on behalf of the enrollees. An HMO can be organized, operated and financed in a variety of ways. For example, an HMO may be organized by physicians, hospitals, community groups, labor unions, government units, insurance companies, etc. Generally speaking, an HMO delivery system is predicated on

3 principles. (1) It is an organized system for the delivery of health care which brings together health care providers. (2) Such arrangement makes available basic health care which the enrolled group might reasonably require, including emphasis on the prevention of illness or disability. (3) The payments will be made on a prepayment basis, whether by the individual enrollees, medicare, medicaid, or through employer-employee arrangements.

How might the HMO concept contribute to alleviating the difficulties posed by the current health care delivery system?

An HMO can directly address itself to the problems of availability, accessibility and continuity, since it is a health care delivery system. It assumes responsibility for actually furnishing to its enrollees those health care services necessary to meet the obligations it undertakes. Thus the HMO occupies a position through which both the accessibility and continuity of care may be affected.

An HMO, by its very nature, may provide incentive toward lessening costs in delivering health care. It has a limited membership prepaying fixed sums of money. The providers are obligated to deliver a specified set of health care services. The fixed amount of income provides incentive to control expenses and costs. The HMO provides a mechanism to analyze costs, expenses and utilization of services, and affords a means to implement measures to enhance efficiency.

The problem of the quality of health care is not susceptible to an easy solution. An HMO is in a position to assess the quality of care provided since it is a closed system. It can study the health of its members, review the records of treatment, and in general, provide a monitoring mechanism.

The need for state authorizing and regulatory legislation.

The administration and committees in both houses of the Federal Congress have given great amounts of time to analysis of the health maintenance organization alternative in connection with national health insurance and federal assistance bills for HMO's. Although legislation was not enacted in 1972, consideration of the topic will probably be resumed in the 93rd Congress. With the increasing public interest, both in the private and government sectors, it may be assumed that the health maintenance organization concept will soon enter a period of growth.

At the present time, few states have a statutory framework tailored to the supervision of health maintenance organizations. Chartering, licensing, contract and rate regulation, and other supervision is being carried out under general insurance laws, hospital and medical service corporation statutes, other special statutes, or not at all. However, the HMO is a unique type of organization. Many provisions of existing laws are inapplicable. Others are highly restrictive or prohibitive to the formation and operation of an HMO. Thus, in view of the growing interest in organizing health maintenance organizations and recognizing the current limitations on their organization in many states due to statutory restrictions, it is appropriate to consider a bill dovetailed to the unique features of HMO's.

Purpose of the Maine bill.

The Maine bill is taken from a model bill as recommended by the National Association of Insurance Commissioners. Its major function is and should clearly authorize the establishment and operation of HMO's. Restrictive provisions in other laws which are inappropriate to HMO's need to be rendered inapplicable. Appropriate grants of authority should be given to enable the HMO's to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient and ethical operation of HMO's. As is the case with insurance and hospital and medical service corporations, HMO's are "affected with the public interest." Regulatory safeguards dovetailed to the unique nature of HMO's are essential. Thus, the purpose of this bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMO's of a wide variety including those based upon the medical care foundation concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of modus operandi is required. But, rather, the HMO concept can be refined and subjected to further experimentation. Second, the bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuses, but also to assist in the future improvement and development of this alternative form of a health care delivery system.