114th MAINE LEGISLATURE

SECOND REGULAR SESSION - 1990

Legislative Document **No. 2337**

S.P. 926 In Senate, February 23, 1990

Submitted by the Department of Professional and Financial Regulation pursuant to Joint Rule 24.

Reference to the Committee on Banking and Insurance suggested and ordered printed.

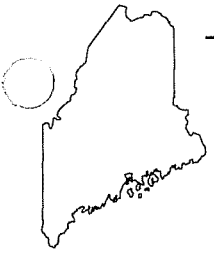
JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator GILL of Cumberland.
Cosponsored by Senator BUSTIN of Kennebec, Representative TRACY of Rome and Representative DONALD of Buxton.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY

An Act Relating to Health Maintenance Organizations.



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

Sec. 1. 24-A MRSA §4202, sub-§§1-A and 1-B are enacted to read:

1-A. Capitated basis. "Capitated basis" means fixed per member per month payment or percentage of premium payment pursuant to which the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

1-B. Carrier. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.

Sec. 2. 24-A MRSA §4202, sub-§6, as enacted by PL 1975, c. 503, is repealed.

Sec. 3. 24-A MRSA §4202, sub-§§7-A and 11 are enacted to read:

7-A. Participating provider. "Participating provider" means a provider as defined in subsection 9 that, under an express or implied contract with the health maintenance organization, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment, directly or indirectly from the health maintenance organization.

11. Uncovered expenditures. "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization for which an enrollee may also be liable.

Sec. 4. 24-A MRSA §4203, sub-§3, ¶I, as enacted by PL 1975, c. 503, is repealed and the following enacted in its place:

I. A financial feasibility plan that includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first 12 months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the State, income and expense statements anticipated from the start of operations until the organization has had net income for at least one year and a statement of the sources of working capital and any other sources of funding;

Sec. 5. 24-A MRSA §4203, sub-§3, ¶M, as enacted by PL 1975, c. 503, is repealed and the following enacted in its place:

M. A description of the proposed quality assurance program, including the formal organization structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

Sec. 6. 24-A MRSA §4203, sub-§3, ¶Q, as enacted by PL 1975, c. 503, is amended to read:

Q. Such other information as the superintendent may reasonably require to make the determinations required in section 4204. ; and

Sec. 7. 24-A MRSA §4203, sub-§3, ¶¶R and S are enacted to read:

R. A description of procedures to be implemented to meet the protection against insolvency requirements in section 4204, subsection 2-A, paragraph D and section 4204-A; and

S. A list of the names and addresses of all physicians and facilities with which the health maintenance organization has or will have agreements.

Sec. 8. 24-A MRSA §4204, sub-§2-A, ¶B, as enacted by PL 1981, c. 501, §51, is amended to read:

B. If the Commissioner of Human Services has determined that a certificate of need is not required, the commissioner makes a determination and provides a certification to the superintendent whether that the following requirements have been met.

~~(1) The applicant has demonstrated the willingness and potential ability to assure that the 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) The applicant has arrangements, established in accordance with regulations promulgated by the Commissioner of Human Services with the advice of the Maine Health Systems Agency or any successor agency, for an ongoing quality of health care assurance program concerning health care processes and outcomes.~~

~~(3) The applicant has a procedure, established in accordance with regulations of the Commissioner of Human Services, to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services and such other matters as may be reasonably required by the commissioner.~~

(4) The health maintenance organization must establish and maintain procedures to ensure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. These procedures must include mechanisms to ensure availability, accessibility and continuity of care.

(5) The health maintenance organization must have an ongoing internal quality assurance program to monitor and evaluate its health care services including primary and specialist physician services, ancillary and preventive health care services across all institutional and noninstitutional settings. The program must include, at a minimum, the following:

(a) A written statement of goals and objectives that emphasizes improved health outcomes in evaluating the quality of care rendered to enrollees;

(b) A written quality assurance plan that describes the following:

(i) The health maintenance organization's scope and purpose in quality assurance;

(ii) The organizational structure responsible for quality assurance activities;

(iii) Contractual arrangements, in appropriate instances, for delegation of quality assurance activities;

(iv) Confidentiality policies and procedures;

(v) A system of ongoing evaluation activities;

(vi) A system of focused evaluation activities;

(vii) A system for reviewing and evaluating provider credentials for acceptance and performing peer review activities; and

(viii) Duties and responsibilities of the designated physician supervising the quality assurance activities;

(c) A written statement describing the system of ongoing quality assurance activities including:

(i) Problem assessment, identification, selection and study;

(ii) Corrective action, monitoring evaluation and reassessment; and

(iii) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(d) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies the method of topic selection, study, data collection, analysis, interpretation and report format; and

(e) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

(6) The health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes must be available to the Commissioner of Human Services.

(7) The health maintenance organization shall ensure the use and maintenance of an adequate patient record system that facilitates documentation and retrieval of clinical information to permit evaluation by the health maintenance organization of the continuity and coordination of patient care and the assessment the quality of health and medical care provided to enrollees.

(8) Enrollee clinical records must be available to the Commissioner of Human Services or an authorized

designee for examination and review to ascertain compliance with this section, or as considered necessary by the Commissioner of Human Services.

(9) The organization must establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

The Commissioner of Human Services shall make the certification required by this paragraph within 60 days of the date of the written decision that a certificate of need was not required. If the commissioner certifies that the health maintenance organization does not meet all of the requirements of this paragraph, ~~he~~ the commissioner shall specify in what respects ~~it~~ the health maintenance organization is deficient.

Sec. 9. 24-A MRSA §4204, sub-§2-A, ¶D, as repealed and replaced by PL 1989, c. 345, §1, is amended to read:

D. The health maintenance organization is financially responsible, complies with the minimum surplus requirements of section 4204-A, and, among other factors, ~~shall~~ can reasonably be expected to meet its obligations to enrollees and prospective enrollees.

~~(1) The health maintenance organization possesses and maintains minimum surplus as follows:~~

~~(a) As of December 31, 1989, $200,000;~~

~~(b) As of December 31, 1990, $300,000; and~~

~~(c) As of December 31, 1991, $400,000.~~

~~(2) A health maintenance organization which reports incurred, but not reported, claims liability in its financial statements as long-term debt shall establish and maintain a liquid cash reserve represented by assets consisting of cash, prime commercial paper, marketable securities with maturities not exceeding 2 years' duration and certificates of deposit issued by banks and thrift institutions located within the United States and which are fully insured by the Federal Deposit Insurance Corporation. The value of the cash reserves shall at least equal the health maintenance organization's claims incurred, but not reported, as determined monthly by methods of claims valuation found acceptable by the superintendent. Any nonprofit health maintenance organization employing fund accounts shall maintain restricted assets in a like manner. These~~

~~funds shall be in addition to and shall not be included as a part of working capital funds required by rule of the Bureau of Insurance.~~

(3) In making the determination whether the health maintenance organization is financially responsible, the superintendent may also consider:

(a) The financial soundness of the health maintenance organization's arrangements for health care services and the schedule of charges used;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a nonprofit hospital or medical service corporation, a government or any other organization for insuring or providing 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;

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

(e) Any arrangements for insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care services.

Sec. 10. 24-A MRSA §4204, sub-§2-A, ¶¶G and H are enacted to read:

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

H. The health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on those employees and officers of the health maintenance organization who have duties as described in paragraph G, in an amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the superintendent.

Sec. 11. 24-A MRSA §4204, sub-§3, as enacted by PL 1975, c. 503, is repealed.

Sec. 12. 24-A MRSA §4204, sub-§3-A is enacted to read:

3-A. Investments. The health maintenance organization shall invest funds only in accordance with chapter 13.

Sec. 13. 24-A MRSA §4204, sub-§§4 to 9 are enacted to read:

4. Uncovered expenditures involving deposit. A health maintenance organization shall deposit with the superintendent or, at the discretion of the superintendent, with any organization or trustee acceptable to the superintendent through which a custodial or controlled account is maintained, cash or securities that are acceptable to the superintendent and that at all times are maintained in a fair market value of not less than an amount equal to the greater of $100,000 or 120% of the health maintenance organization's liability for uncovered expenditures for enrollees as of the end of the most recent calendar quarter, including but not limited to, liability for incurred but not reported claims. If the health maintenance organization's liability for uncovered expenditures increases more than 10% prior to the end of the calendar quarter, the health maintenance organization must, within 10 days of the determination, deposit an amount sufficient to ensure compliance with this section. In the case of domestic health maintenance organizations, "enrollees" for purposes of this subsection means all enrollees of the organization regardless of residence. In the case of foreign health maintenance organizations, "enrollees" for purposes of this subsection means only those enrollees who are residents of this State.

A. The deposit required by this subsection constitutes an admitted asset of the health maintenance organization for purposes of determination of surplus.

B. A health maintenance organization that has made a deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash or securities of equal amount and value. There may also be withdrawn any part of the deposit in excess of the fair market value of the amount of the required deposit. Deposits, substitutions or withdrawals may be made only with the prior written approval of the superintendent.

C. The deposit required by this subsection must be held in trust and must be used only as provided under this section. The superintendent may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees for uncovered expenditures.

D. The superintendent may by rule or order require a health maintenance organization to file annual, quarterly or more

frequent reports of a health maintenance organization's liability for uncovered expenditures. The superintendent may require that the reports include an audit opinion.

E. The superintendent may reduce or eliminate the deposit required by this subsection if the health maintenance organization deposits cash or securities with the Treasurer of State, an insurance supervisory official in the state or jurisdiction of domicile or other official body of that state for the protection of all subscribers and enrollees in a manner substantially similar to that required by this subsection and delivers to the superintendent a certificate to that effect, authenticated by the appropriate state official holding the deposit.

5. Liabilities. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, that are unpaid, and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of those claims.

These liabilities must be computed in accordance with rules promulgated by the superintendent upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

6. Hold harmless. Every contract between a health maintenance organization and a participating provider of health care services must be in writing and must set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee may not be liable to the provider for any sums owed by the health maintenance organization.

A. If the participating provider contract has not been reduced to writing as required by this subsection or the contract fails to contain the required prohibition, the participating provider may not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

B. No participating provider or agent, trustee or assignee of the participating provider, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

7. Continuation of benefits. The superintendent shall require that each health maintenance organization have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been

paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until those covered persons are discharged or upon expiration of benefits. In considering such a plan, the superintendent may require:

A. Insurance adequate to cover the expenses to be paid for continued benefits after an insolvency;

B. That the provider contract obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

C. That insolvency reserves be provided and maintained for that period of claims exposure of a health maintenance organization during which a provider's termination of services is pending pursuant to subsection 8; and

D. Any other arrangements to ensure that benefits are continued as specified in this section.

8. Notice of termination. An agreement to provide health care services between a provider and a health maintenance organization must require that, if the provider terminates that agreement, the provider shall give the health maintenance organization not less than 60 days' notice in advance of termination.

9. Denial. A certificate of authority may be denied only after compliance with the requirements of section 4219.

Sec. 14. 24-A MRSA §4204-A is enacted to read:

§4204-A. Surplus requirements

1. Initial minimum surplus. To qualify for authority as a health maintenance organization, an organization shall have an initial minimum surplus of $1,500,000.

2. Surplus maintained. Except as provided in this section, every health maintenance organization must maintain a minimum surplus equal to the greater of:

A. One million dollars;

B. Two percent of annual premium revenues as reported in the annual financial statement covering the health maintenance organization's immediately preceding fiscal year as filed with the superintendent on the first $150,000,000

of premium and 1% of annual premium on the premium in excess of $150,000,000;

C. An amount equal to the sum of 3 months uncovered health care expenditures as reported on the financial statement covering the health maintenance organization's immediately preceding fiscal year as filed with the superintendent; or

D. An amount equal to the sum of:

(1) Eight percent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the financial statement covering the health maintenance organization's immediately preceding fiscal year as filed with the superintendent; and

(2) Four percent of annual hospital expenditures paid on a managed hospital payment basis as reported on the financial statement covering the health maintenance organization's immediately preceding fiscal year as filed with the superintendent.

3. Exceptions. A health maintenance organization licensed before the effective date of this section must maintain a minimum surplus of:

A. Forty percent of the amount required by subsection 2 until December 31, 1991;

B. Sixty percent of the amount required by subsection 2 until December 31, 1992;

C. Eighty percent of the amount required by subsection 2 until December 31, 1993; and

D. One hundred percent of the amount required by subsection 2 until December 31, 1994.

4. Subordinated debt. Any health maintenance organization that issues a subordinated debt instrument shall structure the debt as follows.

A. In determining surplus, debt may not be considered fully subordinated unless the subordination clause is in a form approved by the superintendent. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

B. Any debt incurred by a note that meets the requirements of this section, and is otherwise acceptable to the

superintendent, may not be considered a liability and must be recorded as equity.

Sec. 15. 24-A MRSA §4209, as enacted by PL 1975, c. 503, is repealed and the following enacted in its place:

§4209. Information to enrollees

1. Information provided annually. Every health maintenance organization must annually provide to its enrollees:

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

B. A description of the organizational structure and operation of the health maintenance organization, including the kind and extent of enrollee participation, and a summary of any material changes since the issuance of the last report;

C. A description of services and information on where and how to secure these services; and

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

2. List of providers. The health maintenance organization must provide to its subscribers, upon enrollment and reenrollment, a list of providers.

3. Notice of material change. Every health maintenance organization must provide 30 days' advance notice to its subscribers of any material change in the operation of the organization that will directly affect the subscribers.

4. Notice of termination of primary care provider. An enrollee must be notified in writing by the health maintenance organization of the termination of the primary care provider that provided health care services to that enrollee. The health maintenance organization must provide assistance to the enrollee in transferring to another participating primary care provider.

5. Access to services. The health maintenance organization shall provide to its subscribers information on how services may be obtained, where additional information on access to services is obtained and a toll free telephone number for calls within the service area of the health maintenance organization.

Sec. 16. 24-A MRSA §4214, sub-§4, as enacted by PL 1975, c. 503, is repealed.

Sec. 17. 24-A MRSA §4216, sub-§1, ¶I-1 is enacted to read:

I-1. The health maintenance organization has failed to meet the surplus requirements of section 4204-A; or

Sec. 18. 24-A MRSA §§4231 to 4233 are enacted to read:

§4231. Insolvency; alternative coverage

1. Continuation of coverage by other insurers. In the event of an insolvency of a health maintenance organization and if satisfactory arrangements for the performance of obligations have not been made as provided for in section 4214, all other insurers that made an offer of coverage to a group contract holder of the insolvent health maintenance organization at the most recent purchase or renewal of coverage prior to the insolvency, upon order of the superintendent, shall offer the enrollees in that group covered by the insolvent health maintenance organization a 30-day enrollment period commencing upon the date of insolvency. Each insurer must offer that group's enrollees of the insolvent health maintenance organization the same coverage and rates that the insurer had offered to enrollees of the group at the most recent purchase or renewal of coverage prior to the insolvency.

2. Allocation of enrollees. If no other insurer had offered coverage to a group contract holder in the insolvent health maintenance organization, or if the superintendent determines that the other health benefit plan or plans lack sufficient health care delivery resources to ensure that health care services will be available and reasonably accessible to all of that group's enrollees in the insolvent health maintenance organization, then the superintendent shall allocate equitably the insolvent health maintenance organization's group contracts among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer such group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

3. Nongroup enrollees. The superintendent shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees who are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health

care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer those nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by that enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

§4232. Replacement coverage

1. Group hospital, medical or surgical expenses, or service benefits. Any insurer or nonprofit health insurance plan that issues replacement coverage with respect to group hospital, medical or surgical expenses or service benefits within a period of 60 days from the date of discontinuance of a prior health maintenance organization contract or policy providing the hospital, medical or surgical expenses or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding insurer's or nonprofit health insurance plan's contract, regardless of any provisions in that contract relating to active employment, hospital confinement or pregnancy.

2. Preexisting conditions. No provision in a succeeding insurer's or nonprofit health insurance plan's contract of replacement coverage that reduces or excludes benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding insurer's or nonprofit health insurance plan's contract, except to the extent that benefits for the condition would have been reduced or excluded under the prior insurer's or nonprofit health insurance plan's contract or policy, may be applied to those enrollees validly covered under the prior insurer's or nonprofit health insurance plan's contract or policy on the date of discontinuance.

§4233. Registration, regulation and supervision of holding company systems

Every domestic health maintenance organization shall be subject to the requirements of section 222, subsections 2 to 9 and subsections 13 to 18, and shall be deemed to be an insurer for purposes of those provisions of chapter 57, subchapters I and II.

STATEMENT OF FACT

The purpose of this bill is to strengthen regulation of health maintenance organizations (HMO), regarding financial viability and continuity of health care services undertaken by physicians in independent practice associations. The bill makes the following changes to the laws governing health maintenance organizations.

1. It provides more definitive terms and outlines responsibilities of a HMO and its providers.

2. It requires that a feasibility plan be filed by those seeking to establish a HMO in Maine.

3. It requires that HMOs disclose their plans for quality control regarding services rendered to subscribers.

4. It requires that a business plan for establishing a HMO contain provisions that address a business failure and how specified providers will then act on any undischarged subscriber's benefits.

5. It modifies standards under which a demonstration of quality of care, correction of deficiencies, if any, and ongoing evaluation of coordination of patient care is to be incorporated in qualifying for a certificate of authority.

6. It sets in place a new requirement for demonstrating financial solidity. A newly formed HMO, as of January 1, 1994, must possess surplus funds equal to $1,500,000 and maintain $1,000,000 thereafter. There is a phase-in period for capitalizing HMOs which is to be accomplished over the 3 intervening years; 40% of these amounts is required in 1991, 60% in 1992, 80% in 1993, and 100% thereafter.

7. It outlines the form of subordinated debt, if any, to be used by a HMO.

8. It requires fidelity bonding for officials of a HMO who handle funds.

9. It makes applicable to HMOs investment standards that insurers must follow.

10. It requires deposit funds to be maintained with the Treasurer of State if the HMO can "balance bill" subscribers. Balance billing occurs when the provider is not fully compensated by the HMO for services rendered.

11. It requires that a hold harmless provision be included in provider contracts to avoid, to the extent possible, balance billing to subscribers of financially distressed or insolvent HMOs.

12. It provides for suspension or revocation of license of a HMO if it fails to maintain adequate surplus funds.

13. It provides for alternative or replacement coverage for subscribers of an insolvent HMO.

14. It requires holding companies controlling a HMO to register with the Bureau of Insurance.