120th MAINE LEGISLATURE

FIRST REGULAR SESSION-2001

Legislative Document **No. 1284**

S.P. 387 In Senate, February 28, 2001

An Act Related to the Financial Regulation of Health Maintenance Organizations.

Submitted by the Department of Professional and Financial Regulation pursuant to Joint Rule 204.

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

JOY J. O'BRIEN
Secretary of the Senate

Presented by Senator LaFOUNTAIN of York.
Cosponsored by Representative O'NEIL of Saco and
Senators: ABROMSON of Cumberland, DOUGLASS of Androscoggin, NUTTING of Androscoggin, Representatives: DUDLEY of Portland, MAYO of Bath.

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

Sec. 1. 24-A MRSA §4204, sub-§4, ¶F is enacted to read:

F. The superintendent may require a health maintenance organization to continue to maintain the deposit required under this subsection after the health maintenance organization has withdrawn from the market in accordance with section 415-A.

Sec. 2. 24-A MRSA §4204, sub-§6, ¶C is enacted to read:

C. In addition to the other provisions in this subsection, if a petition to liquidate an insolvent health maintenance organization is filed with a court of competent jurisdiction, then after the date of filing the petition for liquidation:

(1) Any provider who has rendered a covered service for a subscriber or enrollee of the insolvent health maintenance organization is prohibited from collecting or attempting to collect from the subscriber or enrollee amounts normally payable by the insolvent health maintenance organization; and

(2) A provider or agent, trustee or assignee of the provider may not maintain any action at law against a subscriber or enrollee of the insolvent health maintenance organization to collect amounts for covered services normally payable by the insolvent health maintenance organization.

Nothing in this subsection prohibits a provider from collecting or attempting to collect from a subscriber or enrollee any amounts for services not normally payable by the insolvent health maintenance organization, including applicable copayments or deductibles.

Sec. 3. 24-A MRSA §4204-A, sub-§2, ¶C, as enacted by PL 1989, c. 842, §14, is amended to read:

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~~

Sec. 4. 24-A MRSA §4204-A, sub-§2, ¶D, as enacted by PL 1989, c. 842, §14, is repealed and the following enacted in its place:

D. An amount equal to 8% of annual health care expenditures, except those paid on a capitated basis as reported on the financial statement covering the health maintenance organization's immediately preceding fiscal year as filed with the superintendent; or

Sec. 5. 24-A MRSA §4204-A, sub-§2, ¶E is enacted to read:

E. An amount equal to the company action level risk-based capital as defined in chapter 79.

Sec. 6. 24-A MRSA §4222-B, sub-§§5 and 6, as enacted by PL 1995, c. 332, Pt. O, §8, are amended to read:

5. The requirements of section 222, subsections 2 to 9, subsections 11-A and 11-B and subsections 13 to 18 apply to domestic health maintenance organizations.

6. The requirements of chapter 57, subchapters I and II apply to ~~domestic~~ health maintenance organizations.

Sec. 7. 24-A MRSA §4222-B, sub-§§15 and 16 are enacted to read:

15. The requirements of section 415-A apply to health maintenance organizations.

16. The requirements of sections 3483 and 3484 apply to health maintenance organizations.

Sec. 8. 24-A MRSA §4231, as amended by PL 1995, c. 332, Pt. O, §10, is further amended to read:

§4231. Insolvency or withdrawal; alternative coverage

1. Continuation of coverage by other carriers. In the event of an insolvency of a health maintenance organization and if satisfactory arrangements for the performance of its obligations have not been made as provided for in section 4214, all other carriers that made an offer of coverage to any group contract holder of the insolvent health maintenance organization at the most recent purchase or renewal of coverage, upon order of the superintendent, shall offer the enrollees in the group covered by that contract a 30-day enrollment period that begins on the date of insolvency.

Each carrier shall offer the group's enrollees the same coverage and rates that the carrier had offered to those enrollees at the most recent purchase or renewal of coverage prior to the insolvency, except that a successor health maintenance

organization may increase the group's rate to the extent justified by including the new enrollees in a recalculation of rates using the existing method of rate calculation of the successor carrier or, if the group was covered under a multiple-year contract, to the extent justified to take into account increased health care costs, as approved by the superintendent.

2. Allocation of enrollees. If no other carrier 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.

Sec. 9. 24-A MRSA §4231, sub-§4 is enacted to read:

4. Allocation upon withdrawal. If any group contract holder of a withdrawing health maintenance organization is unable to obtain replacement coverage subsequent to a withdrawal pursuant to section 415-A, the superintendent may allocate equitably the withdrawing health maintenance organization's group contract holders among all health maintenance organizations that operate within a portion of the withdrawing health maintenance organization's service area in accordance with subsection 2.

Sec. 10. 24-A MRSA §4351, sub-§§4 and 5, as enacted by PL 1969, c. 132, §1, are amended to read:

4. All persons in process of organization, or holding themselves out as organizing, or proposing to organize in this State for the purpose of becoming an insurer; ~~and~~

5. All other persons as to whom such provisions are otherwise expressly made applicable by law~~.~~; and

Sec. 11. 24-A MRSA §4351, sub-§6 is enacted to read:

6. Health maintenance organizations, which are considered insurers for the purposes of this subchapter and subchapter II.

Sec. 12. 24-A MRSA §4379, sub-§§1, 3 and 4, as enacted by PL 1969, c. 132, §1, are amended to read:

1. Administration costs. The costs and expenses of administration, including but not limited to the actual and necessary costs of preserving or recovering the assets of the insurer; compensation for all services rendered in the liquidation; any necessary filing fees; the fees and mileage payable to witnesses; and reasonable attorney's fees. Any provider or member claims for covered services under a health maintenance organization contract, including a point-of-service contract, incurred between the date a petition of liquidation is filed and the date coverage terminates may be treated as administration costs under this subsection.

3. Loss claims. All claims under policies for losses incurred, including third party claims, and all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property ~~which~~ that are not under policies, except the first $200 of losses otherwise payable to any claimant under this subsection. All claims under life insurance policies and annuity contracts, whether for death proceeds, annuity proceeds or investment values, ~~shall~~ must be treated as loss claims. Claims ~~shall~~ may not be cumulated by assignment to avoid application of the $200 deductible provision. That portion of any loss for which indemnification is provided by other benefits or advantages recovered or recoverable by the claimant ~~shall~~ may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to ~~his~~ an employee ~~shall~~ may be treated as a gratuity. Any provider or member claims for covered services under a health maintenance organization contract, including a point-of-service contract, not paid under subsection 1 are included in this class.

4. Unearned premiums and small loss claims. Claims under nonassessable policies for unearned premiums or other premium refunds and the first $200 or loss excepted by the deductible provision in subsection 3, except that, if the receiver fails to prorate a premium due to the insurer based on a termination of coverage under this chapter, any resulting unearned premium must be paid to the insured under subsection 1 as an expense of the administration.

SUMMARY

This bill makes several changes to the laws concerning the financial regulation of health maintenance organizations. Specifically, the bill does the following.

1. It clarifies that health maintenance organizations, or HMOs, are subject to the same provisions as authorized insurers regarding the voluntary termination of certificate of authority. The requirements of the Maine Revised Statutes, Title 24-A, section 415-A are made expressly applicable to HMOs with respect to a voluntary partial or total withdrawal from the market. The Superintendent of Insurance is permitted to require a withdrawing HMO to maintain its deposit after the HMO has withdrawn. Currently, it is unclear what processes and requirements would be applicable to an HMO that wishes to voluntarily surrender, or seek modification of, its certificate of authority. The requirements of section 415-A provide guidance as to what is required for these actions and clarify that any such proposal must be carried out pursuant to a plan approved by the superintendent.

2. It prohibits any provider who has rendered a covered service for an enrollee or subscriber of an insolvent HMO from billing the enrollees or subscribers for these services after a petition for liquidation has been filed. In this circumstance, the providers have to seek payment from the HMO or the receiver of the HMO. Claims for covered services incurred between the time a petition for liquidation is filed and the time coverage terminates may be paid by the receiver as costs of administration in a liquidation. It also clarifies that other provider claims for covered services fall within the same priority class as policyholder claims. In addition, if a receiver is unable to prorate a premium when coverage ceases under a liquidation, the receiver must return such an unearned premium to members or subscribers as a cost of administration.

3. It clarifies the appropriate calculation when determining the amount of required minimum surplus as a percentage of health care expenditures and the interrelationship of Title 24-A, chapter 79 and section 4204-A.

4. It clarifies that dividends payable by HMOs, for example, to a parent organization, are subject to the same standards and approval requirements as dividends paid by insurance companies.

5. It makes the receivership laws apply to all authorized HMOs, foreign and domestic.

6. It makes the requirements of the laws concerning bulk insurance and voluntary dissolution expressly applicable to HMOs.

7. It provides that in the continuation of coverage provisions after an HMO insolvency, the superintendent is permitted to take into account increased health care costs in considering replacement rates for multiple-year contracts. The superintendent is also permitted to equitably allocate groups of a withdrawing HMO to other HMOs operating in at least a portion of the same service area.