

**Maine Revised Statute Title 24-A, Chapter 56:
HEALTH MAINTENANCE ORGANIZATIONS**

Table of Contents

Section 4201. SHORT TITLE.....	5
Section 4202. DEFINITIONS (REPEALED).....	5
Section 4202-A. DEFINITIONS.....	5
Section 4203. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS....	8
Section 4204. ISSUANCE OF CERTIFICATE OF AUTHORITY.....	10
Section 4204-A. SURPLUS REQUIREMENTS.....	17
Section 4205. POWERS OF HEALTH MAINTENANCE ORGANIZATIONS.....	18
Section 4205-A. CONTINUITY OF LICENSURE; BUSINESS COMBINATIONS.....	19
Section 4206. GOVERNING BODY.....	20
Section 4207. EVIDENCE OF COVERAGE AND CHARGES FOR HEALTH CARE SERVICES.....	20
Section 4207-A. POINT-OF-SERVICE PRODUCTS.....	21
Section 4208. ANNUAL REPORT.....	23
Section 4209. INFORMATION TO ENROLLEES.....	24
Section 4210. OPEN ENROLLMENT.....	25
Section 4210-A. CONTINUITY OF HEALTH INSURANCE COVERAGE (REPEALED).....	26
Section 4211. COMPLAINT SYSTEM.....	26
Section 4212. PROHIBITED PRACTICES.....	27
Section 4213. REGULATION OF AGENTS.....	28
Section 4214. POWERS OF INSURERS AND NONPROFIT HOSPITAL OR MEDICAL SERVICE CORPORATIONS.....	28
Section 4215. EXAMINATIONS.....	29
Section 4216. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY.....	29
Section 4217. REHABILITATION, LIQUIDATION OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATIONS.....	31
Section 4218. REGULATIONS.....	31
Section 4219. ADMINISTRATIVE PROCEDURES.....	31
Section 4220. FEES.....	32
Section 4221. PENALTIES AND ENFORCEMENT.....	32
Section 4222. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS.....	33
Section 4222-A. RULES.....	33
Section 4222-B. APPLICABILITY.....	34
Section 4223. FILINGS AND REPORTS AS PUBLIC DOCUMENTS.....	36
Section 4224. CONFIDENTIALITY; LIABILITY; ACCESS TO RECORDS.....	36

Section 4224-A. LOSS INFORMATION (REPEALED)	37
Section 4225. COMMISSIONER OF HEALTH AND HUMAN SERVICE'S AUTHORITY TO CONTRACT	37
Section 4226. FEDERAL LEGISLATION	37
Section 4227. CHOICE OF ALTERNATIVE COVERAGE	37
Section 4228. UTILIZATION REVIEW DATA	38
Section 4229. ACQUIRED IMMUNE DEFICIENCY SYNDROME	39
Section 4230. TRADE PRACTICES AND FRAUDS (REPEALED)	39
Section 4231. INSOLVENCY OR WITHDRAWAL; ALTERNATIVE COVERAGE	39
Section 4232. REPLACEMENT COVERAGE	40
Section 4233. REGISTRATION, REGULATION AND SUPERVISION OF HOLDING COMPANY SYSTEMS	40
Section 4233-A. EXTENSION OF COVERAGE FOR DEPENDENT CHILDREN	41
Section 4233-B. MANDATORY OFFER TO EXTEND COVERAGE FOR DEPENDENT CHILDREN UP TO 25 YEARS OF AGE (CONTAINS TEXT WITH VARYING EFFECTIVE DATES)	41
Section 4234. CHILD COVERAGE	42
Section 4234-A. MENTAL HEALTH SERVICES COVERAGE	43
Section 4234-B. MATERNITY AND ROUTINE NEWBORN CARE	48
Section 4234-C. NEWBORN CHILDREN COVERAGE	48
Section 4234-D. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR CANCER	49
Section 4234-E. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR HIV OR AIDS	50
Section 4235. STANDARDIZED CLAIM FORMS	51
Section 4236. CHIROPRACTORS IN HEALTH MAINTENANCE ORGANIZATIONS	51
Section 4237. COVERAGE FOR BREAST CANCER TREATMENT	53
Section 4237-A. SCREENING MAMMOGRAMS	53
Section 4238. MEDICAL FOOD COVERAGE FOR INBORN ERROR OF METABOLISM	54
Section 4239. MEDICAL CHILD SUPPORT	55
Section 4240. COVERAGE FOR DIABETES SUPPLIES	55
Section 4241. GYNECOLOGICAL AND OBSTETRICAL SERVICES	55
Section 4242. COVERAGE FOR PAP TESTS (REALLOCATED FROM TITLE 24-A, SECTION 4240)	56
Section 4243. LIMITS ON PRIORITY LIENS; SUBROGATION	56
Section 4244. COVERAGE FOR PROSTATE CANCER SCREENING (REALLOCATED FROM TITLE 24-A, SECTION 4243)	57
Section 4245. NCQA ACCREDITATION SURVEY REPORT	58
Section 4246. COVERAGE FOR SERVICES PROVIDED BY REGISTERED NURSE FIRST ASSISTANTS	58

Section 4247. COVERAGE FOR CONTRACEPTIVES (REALLOCATED FROM TITLE 24-A, SECTION 4245)..... 59

Section 4248. COVERAGE FOR SERVICES OF CERTIFIED NURSE PRACTITIONERS; CERTIFIED NURSE MIDWIVES (REALLOCATED FROM TITLE 24-A, SECTION 4245)..... 60

Section 4249. MANDATED OFFER OF DOMESTIC PARTNER BENEFITS..... 61

Section 4250. COVERAGE FOR HOSPICE CARE SERVICES (REALLOCATED FROM TITLE 24-A, SECTION 4249)..... 62

Section 4251. COVERAGE FOR GENERAL ANESTHESIA FOR DENTISTRY (REALLOCATED FROM TITLE 24-A, SECTION 4249)..... 63

Section 4252. OFFER OF COVERAGE FOR BREAST REDUCTION SURGERY AND SYMPTOMATIC VARICOSE VEIN SURGERY..... 64

Section 4253. ENROLLMENT FOR INDIVIDUALS OR FAMILIES ESTABLISHING ELIGIBILITY FOR MAINECARE..... 64

Section 4254. COVERAGE FOR COLORECTAL CANCER SCREENING..... 65

Section 4255. COVERAGE FOR HEARING AIDS (REALLOCATED FROM TITLE 24-A, SECTION 4253)..... 65

Section 4256. COVERAGE FOR MEDICALLY NECESSARY INFANT FORMULA (REALLOCATED FROM TITLE 24-A, SECTION 4254)..... 66

Section 4257. COVERAGE FOR SERVICES PROVIDED BY INDEPENDENT PRACTICE DENTAL HYGIENIST..... 67

24-A §4201. SHORT TITLE

This chapter may be cited as the Health Maintenance Organization Act of 1975. [1975, c. 503, (NEW).]

SECTION HISTORY

1975, c. 503, (NEW).

24-A §4202. DEFINITIONS

(REPEALED)

SECTION HISTORY

1975, c. 503, (NEW). 1989, c. 842, §§1-3 (AMD). 1991, c. 709, §1 (RP).

24-A §4202-A. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1991, c. 709, §2 (NEW).]

1. Basic health care services. "Basic health care services" means health care services that an enrolled population might reasonably require in order to be maintained in good health and includes, at a minimum, emergency care, inpatient hospital care, inpatient physician services, outpatient physician services, ancillary services such as x-ray services and laboratory services and all benefits mandated by statute and mandated by rule applicable to health maintenance organizations. The superintendent may adopt rules defining "basic health care services" to be provided by health maintenance organizations. In adopting such rules, the superintendent shall consider the coverages that have traditionally been provided by health maintenance organizations; the need for flexibility in the marketplace; and the importance of providing multiple options to employers and consumers. The superintendent may not require that all health benefit plans offered by health maintenance organizations meet or exceed each of the particular requirements of standard or basic health plans specified in Bureau of Insurance Rule, Chapter 750. The superintendent may select required services from among those set forth in Bureau of Insurance Rule, Chapter 750 and shall permit reasonable, but not excessive or unfairly discriminatory, variations in the copayment, coinsurance, deductible and other features of such coverage, except that these features must meet or exceed those required in benefits mandated by statute. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

[2001, c. 218, §1 (AMD) .]

2. Capitated basis. "Capitated basis" has the following meanings.

A. "Capitated basis" means fixed per-member, per-month payments or percentage-of-premium payments pursuant to which the provider assumes 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. [1991, c. 709, §2 (NEW).]

B. "Capitated basis," in the context of a point-of-service option plan, means prepayment that considers provision of in-plan covered services as described in paragraph A and that considers out-of-plan indemnity benefits reimbursed pursuant to the terms of a point-of-service product approved pursuant to section 4207-A. [1991, c. 709, §2 (NEW).]

[1991, c. 709, §2 (NEW) .]

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

[1991, c. 709, §2 (NEW) .]

4. Copayment. "Copayment" means an amount an enrollee must pay in order to receive a specific service that is not fully prepaid.

[1991, c. 709, §2 (NEW) .]

5. Deductible. "Deductible" means the amount an enrollee is responsible to pay out of pocket before a health maintenance organization begins to pay the costs associated with treatment.

[1991, c. 709, §2 (NEW) .]

6. Enrollee. "Enrollee" means an individual who is enrolled in a health maintenance organization.

[1991, c. 709, §2 (NEW) .]

7. Evidence of coverage. "Evidence of coverage" means any certificate, agreement or contract issued to a group contract holder or an enrollee setting out the coverage to which an enrollee is entitled.

[1991, c. 709, §2 (NEW) .]

8. Group contract holder. "Group contract holder" means an entity or person that has purchased coverage from a health maintenance organization that provides, at a minimum, basic health care services to enrollees.

[1991, c. 709, §2 (NEW) .]

9. Health care services. "Health care services" means any services included in the furnishing of medical care, dental care or hospitalization to an individual, or any services incident to the furnishing of that care or hospitalization, as well as the furnishing of any other services to an individual to prevent, alleviate, cure or heal human illness or injury.

[1991, c. 709, §2 (NEW) .]

10. Health maintenance organization. "Health maintenance organization" means a public or private organization that is organized under the laws of the Federal Government, this State, another state or the District of Columbia or a component of such an organization, and that:

A. Provides, arranges or pays for, or reimburses the cost of, health care services, including, at a minimum, basic health care services to enrolled participants, except that health maintenance organizations contracting with the State Government or the Federal Government to service Medicaid or Medicare populations may limit the services they provide under the contracts consistent with the terms of those contracts if such basic health care services are provided to those populations by other means; [1995, c. 673, Pt. D, §1 (AMD).]

B. Is compensated, except for reasonable copayments, for basic health care services to enrolled participants solely on a predetermined periodic rate basis, except that the organization is not prohibited from having a provision in a group contract allowing an adjustment of premiums based upon the actual health services utilization of the enrollees covered under the contract, and except that such a contract may not be sold to an eligible group subject to the community rating requirements of section 2808-B; [1993, c. 645, Pt. A, §5 (AMD).]

C. Provides physicians' services primarily directly through physicians who are either employees or partners of that organization or through arrangements with individual physicians or one or more groups of physicians organized on a group-practice or individual-practice basis under which those physicians or groups are provided effective incentives to avoid unnecessary or unduly costly utilization, regardless of whether a physician is individually compensated primarily on a fee-for-service basis or otherwise. The organization may discharge its obligation through a point-of-service option product by reimbursing out-of-plan providers pursuant to the terms contained in the group contract holder's group contract. Receipt of out-of-plan covered services by an enrollee does not obligate the organization for an enrollee's responsibilities to meet copayments or deductibles; and [1991, c. 709, §2 (NEW).]

D. Ensures the availability, accessibility and quality, including effective utilization, of the health care services that it provides or makes available through clearly identifiable focal points of legal and administrative responsibility. [1991, c. 709, §2 (NEW).]

Nothing in this subsection prevents a health maintenance organization from providing fee-for-service health care services as well as health maintenance organization services. A health care provider or affiliated entity that does not offer health insurance or health benefit plans may not be or become a health maintenance organization subject to this chapter solely by reason of arrangements with insurers or hospital or medical service organizations for reimbursement in whole or in part on a capitated basis, the financial risk to the provider or affiliated entity associated with reimbursement arrangements with such 3rd-party payors or the furnishing by the provider or affiliated entity of utilization or case management services.

[1995, c. 673, Pt. D, §1 (AMD) .]

11. In-plan covered services. "In-plan covered services" means covered health care services obtained from providers who are employed by, under contract with, referred by or otherwise affiliated with the health maintenance organization. "In-plan covered services" includes emergency services.

[1991, c. 709, §2 (NEW) .]

12. Nonprofit hospital or medical service organization. "Nonprofit hospital or medical service organization" means any organization defined in and authorized to act under Title 24, chapter 19.

[1991, c. 709, §2 (NEW) .]

12-A. NCQA accreditation survey report. "NCQA accreditation survey report" means the unpublished, detailed survey report to a health maintenance organization by the National Committee for Quality Assurance upon completion of NCQA's accreditation survey of the health maintenance organization.

[1999, c. 256, Pt. Q, §1 (NEW) .]

13. Out-of-plan covered services. "Out-of-plan covered services" means nonemergency, covered health care services obtained without a referral from providers who are not otherwise employed by, under contract with or otherwise affiliated with the health maintenance organization or from affiliated specialists.

[1991, c. 709, §2 (NEW) .]

14. Participating provider. "Participating provider" means a provider as defined in subsection 18 that, under an express or implied contract with a 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.

[1991, c. 709, §2 (NEW) .]

15. Person. "Person" means an individual, firm, partnership, corporation, association, syndicate, organization, society, business trust, attorney-in-fact or any legal entity.

[1991, c. 709, §2 (NEW) .]

16. Point-of-service option. "Point-of-service option" means a health maintenance organization product that allows an enrollee to select either the comprehensive health care benefits of the health maintenance organization or care from a provider of the enrollee's choice outside the health maintenance organization network with traditional indemnity benefits. A point-of-service option in which the risk for out-of-plan covered services of a health maintenance organization is shared with a reinsurer must meet the requirements of this chapter applicable to the indemnity benefits provided by a health maintenance organization.

[1991, c. 709, §2 (NEW) .]

17. Point-of-service product. "Point-of-service product" means a product that includes both in-plan covered services and out-of-plan covered services.

[1991, c. 709, §2 (NEW) .]

18. Provider. "Provider" means a physician, hospital or person that is licensed or otherwise authorized in this State to furnish health care services.

[1991, c. 709, §2 (NEW) .]

19. Superintendent. "Superintendent" means the Superintendent of Insurance.

[1991, c. 709, §2 (NEW) .]

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

[1991, c. 709, §2 (NEW) .]

SECTION HISTORY

1991, c. 709, §2 (NEW). 1993, c. 645, §A5 (AMD). 1995, c. 673, §D1 (AMD). 1999, c. 222, §1 (AMD). 1999, c. 256, §Q1 (AMD). 2001, c. 218, §1 (AMD).

24-A §4203. ESTABLISHMENT OF HEALTH MAINTENANCE ORGANIZATIONS

1. Subject to the Maine Certificate of Need Act of 2002, a person may apply to the superintendent for and obtain a certificate of authority to establish, maintain, own, merge with, organize or operate a health maintenance organization in compliance with this chapter. A person may not establish, maintain, own, merge with, organize or operate a health maintenance organization in this State either directly as a division or a line of business or indirectly through a subsidiary or affiliate, 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 chapter.

[2003, c. 510, Pt. A, §19 (AMD) .]

2. Every existing health maintenance organization as of the effective date of this chapter shall submit an application for a certificate of authority under subsection 3 within 30 days of the effective date of this chapter. Each such applicant may continue to operate until the superintendent 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.

[1975, c. 503, (NEW) .]

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 prescribed by the superintendent 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; [1975, c. 503, (NEW) .]

B. A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant; [1975, c. 503, (NEW) .]

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; [1975, c. 503, (NEW) .]

D. A copy of any contract made or to be made between any providers or persons listed in paragraph C and the applicant; [1975, c. 503, (NEW) .]

E. A statement generally describing the health maintenance organization, its health care services, facilities and personnel; [1975, c. 503, (NEW) .]

F. A copy of the form of evidence of coverage to be issued to the enrollees; [1975, c. 503, (NEW) .]

G. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations; [1975, c. 503, (NEW) .]

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 superintendent directs that additional or more recent financial information is required for the proper administration of this chapter; [1975, c. 503, (NEW) .]

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; [1989, c. 842, §4 (RPR) .]

J. A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the superintendent 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; [1975, c. 503, (NEW) .]

K. A statement reasonably describing the geographic area or areas to be served; [1975, c. 503, (NEW) .]

L. A description of the complaint and grievance procedures to be utilized as required under section 4303, subsection 4 and section 4211; [1995, c. 673, Pt. D, §2 (AMD).]

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; [1989, c. 842, §5 (RPR).]

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; [1975, c. 503, (NEW).]

O. A schedule of rates with supporting actuarial and other data; [1975, c. 503, (NEW).]

P. A description of a procedure 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 Human Services; [1975, c. 503, (NEW).]

Q. Such other information as the superintendent may reasonably require to make the determinations required in section 4204; [1989, c. 842, §6 (AMD).]

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 [1989, c. 842, §7 (NEW).]

S. A list of the names and addresses of all physicians and facilities with which the health maintenance organization has or will have agreements. If products are offered that pay full benefits only when providers within a subset of the contracted physicians or facilities are utilized, a list of the providers in that limited network must be included, as well as a list of the geographic areas where the products are offered. This paragraph may not be construed to prohibit a health maintenance organization from offering a health plan that includes financial provisions designed to encourage members to use designated providers in a network in accordance with section 4303, subsection 1, paragraph A. [2003, c. 469, Pt. E, §18 (AMD).]

[2003, c. 469, Pt. E, §18 (AMD) .]

4. Each application for a certificate of authority shall be made in duplicate. Upon receipt of an application for a certificate of authority, the superintendent shall immediately transfer one copy to the Commissioner of Health and Human Services.

[1981, c. 501, §48 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §4 (AMD). 1979, c. 216, §1 (AMD). 1981, c. 501, §48 (AMD). 1989, c. 842, §§4-7 (AMD). 1993, c. 702, §A11 (AMD). 1995, c. 332, §O1 (AMD). 1995, c. 673, §D2 (AMD). 1997, c. 370, §F1 (AMD). 2003, c. 469, §E18 (AMD). 2003, c. 510, §A19 (AMD). 2003, c. 689, §B7 (REV).

24-A §4204. ISSUANCE OF CERTIFICATE OF AUTHORITY

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

A. Concurrently with filing an application for issuance of certificate of authority with the superintendent, the applicant shall also file an application for a certificate of need pursuant to Title 22, chapter 103-A. [2003, c. 510, Pt. A, §20 (AMD).]

B. The superintendent shall take no final action with regard to the application until he has been informed by the Department of Health and Human Services whether or not the application for the certificate of need has been approved, denied or deemed not to be required. The Department of Health and Human Services shall transmit to the superintendent a copy of its written decision on the application for a certificate of need. [1981, c. 501, §49 (AMD); 2003, c. 689, Pt. B, §6 (REV) .]

[2003, c. 510, Pt. A, §20 (AMD); 2003, c. 689, Pt. B, §6 (REV) .]

2.

[1981, c. 501, §50 (RP) .]

2-A. The superintendent shall issue or deny a certificate of authority to any person filing an application pursuant to section 4203 within 50 business days of receipt of the notice from the Department of Health and Human Services that the applicant has been granted a certificate of need or, if a certificate of need is not required, within 50 business days of receipt of notice from the Department of Health and Human Services that the applicant is in compliance with the requirements of paragraph B. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 4220 if the superintendent is satisfied that the following conditions are met.

A. The Commissioner of Health and Human Services certifies that the health maintenance organization has received a certificate of need or that a certificate of need is not required pursuant to Title 22, chapter 103-A. [2003, c. 510, Pt. A, §21 (AMD); 2003, c. 689, Pt. B, §7 (REV) .]

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

(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 Health and 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 Health and Human Services or an authorized designee for examination and review to ascertain compliance with this section, or as considered necessary by the Commissioner of Health and 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 Health and 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, the commissioner shall specify in what respects the health maintenance organization is deficient. [1989, c. 842, §8 (AMD); 2003, c. 689, Pt. B, §7 (REV).]

C. The health maintenance organization conforms to the definition under section 4202-A, subsection 10. [1991, c. 709, §3 (AMD).]

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

- (1) In a determination of minimum surplus requirements, the following terms have the following meanings.
 - (a) "Admitted assets" means assets recognized by the superintendent pursuant to section 901-A. For purposes of this chapter, the asset value is that contained in the annual statement of the corporation as of December 31st of the year preceding the making of the investment or contained in any audited financial report, as defined in section 221-A, of more current origin.
 - (b) "Reserves" means those reserves held by corporations subject to this chapter for the protection of subscribers. For purposes of this chapter, the reserve value is that contained in the annual statement of the corporation as of December 31st of the preceding year or any audited financial report, as defined in section 221-A, of more current origin.
- (2) 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 that contains a covenant consistent with subsection 6; 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. [2007, c. 466, Pt. D, §7 (AMD).]

E. The enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to section 4206. [1981, c. 501, §51 (NEW).]

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. [1981, c. 501, §51 (NEW).]

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. [1989, c. 842, §10 (NEW).]

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. [1989, c. 842, §10 (NEW).]

I. If any agreement, as set forth in paragraph D, subparagraph (2), division (c), is made by the health maintenance organization, the entity executing the agreement with the health maintenance organization must demonstrate to the superintendent's satisfaction that the entity has sufficient unencumbered surplus funds to cover the assured payments under the agreement, otherwise the superintendent shall disallow the agreement. In considering approval of such an agreement, the superintendent shall consider the entity's record of earnings for the most recent 3 years, the risk characteristics of its investments and whether its investments and other assets are reasonably liquid and available to make payments for health services. [1995, c. 332, Pt. O, §2 (AMD).]

J. [2001, c. 410, Pt. A, §8 (RP).]

K. The health maintenance organization provides a spectrum of providers and services that meet patient demand. [1993, c. 702, Pt. B, §1 (NEW).]

L. The health maintenance organization meets the requirements of section 4303, subsection 1. [1995, c. 673, Pt. D, §3 (RPR).]

M. The health maintenance organization demonstrates a plan for providing services for rural and underserved populations and for developing relationships with essential community providers within the area of the proposed certificate. The health maintenance organization must make an annual report to the superintendent regarding the plan. [1993, c. 702, Pt. B, §1 (NEW).]

N. Beginning July 1, 1995, a health maintenance organization that offers coverage to groups in the State shall offer coverage for purchase by individuals. [1995, c. 332, Pt. I, §2 (AMD).]

O. Each health maintenance organization shall provide basic health care services. [1999, c. 222, §2 (NEW).]

The applicant shall furnish, upon request of the superintendent, any information necessary to make any determination required pursuant to this subsection.

[2007, c. 466, Pt. D, §7 (AMD) .]

3.

[1989, c. 842, §11 (RP) .]

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

A. The health maintenance organization shall maintain asset valuation reserves consistent with industry standards for management of investments by life and health insurers. [1993, c. 702, Pt. A, §12 (NEW).]

B. Notwithstanding any limitation stated in section 1156, subsection 2, paragraph D, a health maintenance organization may invest in real property or interests in real property located in the United States, held directly or evidenced by partnership interests, stock of corporations, trust certificates or other instruments and acquired:

- (1) As an investment for the production of income or to be improved or developed for that investment purpose; or
- (2) For the convenient accommodation of the organization's business.

After giving effect to any of those investments, the aggregate amount of investments made under subparagraph (1) may not exceed 20% of the health maintenance organization's total admitted assets; the aggregate amount of investments made under subparagraph (2) may not exceed 15% of the organization's total admitted assets; and the aggregate amount of investments made under this paragraph may not exceed 25% of the organization's total admitted assets. Investments under subparagraph (1) in any single property, including improvements on that property, may not in the aggregate exceed 2% of the corporation's total admitted assets. [1993, c. 702, Pt. A, §12 (NEW).]

C. In addition to the investments permitted under paragraph B, a health maintenance organization may invest in real estate, including leasehold estates, for the convenient accommodation of its business, including hospitals, medical clinics, medical professional buildings and any other facility that is to be used in the provision of health care services, or real estate for rental to an affiliated health care provider or any other health care provider under contract with the health maintenance organization to provide health care services, and that facility must be used in the provision of health care services to members of the health maintenance organization by that provider.

- (1) A parcel of real estate acquired under this subsection may include excess space for rent to others if it is reasonably anticipated that that excess will be required by the health maintenance organization for expansion or if the excess is reasonably required in order to have one or more buildings that function as an economic unit.
- (2) Real estate subject to this subsection may be subject to a mortgage.
- (3) The admitted value of the investment may not exceed the greater of the health maintenance organization's equity or 20% of the corporation's admitted assets, and the aggregate investment in real estate held under paragraph B and under this paragraph may not exceed 40% of the corporation's admitted assets, except with the approval of the superintendent if the superintendent finds that those percentages of the corporation's admitted assets are insufficient to provide for the convenient accommodation of the health maintenance organization's business. Investments under

this subsection in any single property, including improvements on that property, may not in the aggregate exceed 5% of the corporation's total admitted assets. [1993, c. 702, Pt. A, §12 (NEW).]

D. Notwithstanding any provisions of this section and chapter 13-A allowing other investments, a health maintenance organization shall maintain cash or investment grade obligations, as defined in section 1151-A, that at all times have a fair market value of not less than 100% of the organization's liability for claims payable and incurred, but not reported, claims, unearned premiums, unpaid claims adjustment expenses and, as applicable, any statutory, special or additional reserves provided by the health maintenance organization for the benefit of members as of the most recent calendar quarter prepared on the basis of statutory accounting principles. If the organization's liability for claims payable and incurred, but not reported, claims increased more than 10% prior to the end of the calendar quarter, the organization must, within 10 days of the determination, reallocate its investments to ensure compliance with this paragraph. The investments required by this paragraph constitute admitted assets of the organization. [1999, c. 715, §19 (AMD).]

E. The superintendent may establish risk-based capital standards for health maintenance organizations, their subsidiaries and controlled affiliates that engage in health care related business activities that the parent corporation conducts. [1993, c. 702, Pt. A, §12 (NEW).]

[1999, c. 715, §19 (AMD) .]

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. [1989, c. 842, §13 (NEW).]

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. [1989, c. 842, §13 (NEW).]

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. [1989, c. 842, §13 (NEW).]

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. [1989, c. 842, §13 (NEW).]

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. [1989, c. 842, §13 (NEW).]

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. [2001, c. 88, §1 (NEW).]

[2001, c. 88, §1 (AMD) .]

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.

[1989, c. 842, §13 (NEW) .]

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. [1989, c. 842, §13 (NEW).]

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. [1989, c. 842, §13 (NEW).]

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. [2001, c. 88, §2 (NEW).]

[2001, c. 88, §2 (AMD) .]

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; [1989, c. 842, §13 (NEW).]

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; [1989, c. 842, §13 (NEW).]

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 [1989, c. 842, §13 (NEW).]

D. Any other arrangements to ensure that benefits are continued as specified in this section. [1989, c. 842, §13 (NEW).]

[1989, c. 842, §13 (NEW) .]

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. That agreement must not require more than 90 days' notice after an initial participation period not to exceed 6 months. If the health maintenance organization has a net loss of 5 or more primary care physicians in any county in any 30-day period, the health maintenance organization shall notify the Bureau of Insurance in writing within 10 days of acquiring knowledge of that loss.

[1989, c. 842, §13 (NEW) .]

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

[1989, c. 842, §13 (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §5 (AMD). 1979, c. 216, §§2-5 (AMD). 1981, c. 501, §§49-51 (AMD). 1985, c. 704, §6 (AMD). 1989, c. 345, §1 (AMD). 1989, c. 842, §§8-13 (AMD). 1991, c. 709, §3 (AMD). 1993, c. 313, §32 (AMD). 1993, c. 702, §§A12,B1 (AMD). RR 1993, c. 1, §67 (COR). 1995, c. 332, §§I1,2,O2 (AMD). 1995, c. 673, §D3 (AMD). 1999, c. 222, §2 (AMD). 1999, c. 715, §19 (AMD). 2001, c. 72, §19 (AMD). 2001, c. 88, §§1,2 (AMD). 2001, c. 410, §A8 (AMD). 2003, c. 510, §§A20,21 (AMD). 2003, c. 689, §B6 (REV). 2007, c. 466, Pt. D, §7 (AMD).

24-A §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.

[1989, c. 842, §14 (NEW) .]

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; [1989, c. 842, §14 (NEW).]

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; [1989, c. 842, §14 (NEW).]

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; [2001, c. 88, §3 (AMD).]

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 [2001, c. 88, §4 (RPR).]

E. An amount equal to the company action level risk-based capital as defined in chapter 79. [2001, c. 88, §5 (NEW).]

[2001, c. 88, §§3-5 (AMD).]

2-A. Additional surplus. A health maintenance organization that otherwise possesses surplus funds as required under this section shall also maintain surplus in a reasonable amount as determined by the superintendent in relation to indemnity risks assumed through the issuance of a point-of-service product, net of any applicable reinsurance.

[1991, c. 709, §4 (NEW).]

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; [1989, c. 842, §14 (NEW).]

B. Sixty percent of the amount required by subsection 2 until December 31, 1992; [1989, c. 842, §14 (NEW).]

C. Eighty percent of the amount required by subsection 2 until December 31, 1993; and [1989, c. 842, §14 (NEW).]

D. One hundred percent of the amount required by subsection 2 until December 31, 1994. [1989, c. 842, §14 (NEW).]

[1989, c. 842, §14 (NEW).]

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. [1989, c. 842, §14 (NEW).]

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. [1989, c. 842, §14 (NEW).]

[1989, c. 842, §14 (NEW).]

SECTION HISTORY

1989, c. 842, §14 (NEW). 1991, c. 709, §4 (AMD). 2001, c. 88, §§3-5 (AMD).

24-A §4205. POWERS OF HEALTH MAINTENANCE ORGANIZATIONS

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

A. Subject to such licensure laws or regulations as are applicable, 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; [1975, c. 503, (NEW).]

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; [1975, c. 503, (NEW).]

C. The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization; [1975, c. 503, (NEW).]

D. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration; [1975, c. 503, (NEW).]

E. The contracting with an insurance company licensed in this State for the provision of insurance or indemnity or with a nonprofit hospital or medical service organization for reimbursement against the cost of health care services provided by the health maintenance organization; [1975, c. 503, (NEW).]

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

(1) Additional health care services;

(2) Indemnity benefits covering out-of-area services;

(3) Indemnity benefits, in addition to those relating to out-of-area services. [1975, c. 503, (NEW).]

[1975, c. 503, (NEW).]

SECTION HISTORY

1975, c. 503, (NEW).

24-A §4205-A. CONTINUITY OF LICENSURE; BUSINESS COMBINATIONS

When a health maintenance organization authorized pursuant to this chapter merges or consolidates with an insurer or a nonprofit hospital, medical or health care service organization and operations of the surviving entity include those of a health maintenance organization, the surviving entity succeeds on a continuing basis to the authority possessed by the merging entities if: [1993, c. 702, Pt. A, §13 (NEW).]

1. Plan approved. The superintendent has approved the plan of merger or consolidation, pursuant to section 4203, subsection 1;

[1993, c. 702, Pt. A, §13 (NEW).]

2. Entity financially qualified. The entity is financially qualified pursuant to the provisions of sections 410 and 4204-A; and

[1993, c. 702, Pt. A, §13 (NEW).]

3. Entity otherwise qualified. The entity is otherwise qualified pursuant to this chapter.

[1993, c. 702, Pt. A, §13 (NEW).]

SECTION HISTORY

1993, c. 702, §A13 (NEW).

24-A §4206. GOVERNING BODY

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

[1975, c. 503, (NEW) .]

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.

[1975, c. 503, (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW) .

24-A §4207. EVIDENCE OF COVERAGE AND CHARGES FOR HEALTH CARE SERVICES

1. Every person who has enrolled as a legal resident of this State in a health maintenance organization is entitled to evidence of coverage. If the enrollee obtains coverage under a health maintenance organization through an insurance policy or contract whether by option or otherwise, the insurer, nonprofit hospital and medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

[1975, c. 503, (NEW) .]

2. No evidence of coverage, or amendment thereto, or underlying contract may be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, amendment thereto and any underlying contract, has been filed with and approved by the superintendent. A filing required under this section must be made electronically in a format required by the superintendent unless exempted by rule adopted by the superintendent. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2009, c. 14, §6 (AMD) .]

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 4212; and [1975, c. 503, (NEW) .]

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

Any subsequent change shall be evidenced in a separate document issued to the enrollee prior to the change. [1975, c. 503, (NEW).]

[1975, c. 503, (NEW) .]

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 superintendent under the laws governing health insurance, or nonprofit hospital or medical service organization, in which event the filing and approval provisions of such laws shall apply.

[1975, c. 503, (NEW) .]

5. A schedule or an amendment to a schedule of charge for enrollee health coverage for health care services may not be used by any health maintenance organization unless it complies with section 2736, 2808-B or 2839, whichever is applicable.

[2003, c. 469, Pt. E, §19 (AMD) .]

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.

[1975, c. 503, (NEW) .]

7. The superintendent 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 superintendent disapproves such filing, he shall notify the filer. In the notice, the superintendent 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 superintendent does not disapprove any form or schedule of charges within 30 days of the filing of such form or charges, they shall be deemed approved.

[1975, c. 503, (NEW) .]

8. The superintendent 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.

[1975, c. 503, (NEW) .]

9. A health maintenance organization may issue a Medicare supplement policy. Chapter 67 and any rules adopted pursuant to that chapter shall apply to health maintenance organizations issuing Medicare supplement policies, except when that application is inconsistent with that chapter.

[1989, c. 27, §2 (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW). 1989, c. 27, §2 (AMD). 1993, c. 645, §A6 (AMD). 1995, c. 332, §03 (AMD). 2003, c. 469, §E19 (AMD). 2009, c. 14, §6 (AMD).

24-A §4207-A. POINT-OF-SERVICE PRODUCTS

1. Product design; mandatory requirements. A point-of-service product, filed and approved for use subject to the requirements of section 4207, subsection 4, at a minimum must:

- A. Provide all services required by law to be provided by health maintenance organizations as in-plan covered services, including emergency services; [1991, c. 709, §5 (NEW).]
- B. Provide incentives for enrollees to use in-plan covered services; and [1991, c. 709, §5 (NEW).]
- C. Offer out-of-plan covered services only if those services are provided by the point-of-service product on an in-plan basis. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

2. Product design; optional provisions. A point-of-service product may:

- A. Limit or exclude specific types of services from coverage when obtained out of plan; [1991, c. 709, §5 (NEW).]
- B. Include annual out-of-pocket limits and annual and lifetime maximum benefit allowances for out-of-plan covered services that are separate from any limits and allowances applied to in-plan covered services; [1991, c. 709, §5 (NEW).]
- C. Limit the groups to which the point-of-service product is offered. If the point-of-service product is offered to a group, it must be offered to all eligible members of that group; and [1991, c. 709, §5 (NEW).]
- D. Include those services that an enrollee obtains from a participating physician for which proper authorization was not given. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

3. Product limitations and exclusions. A health maintenance organization is subject to the following requirements as to its point-of-service product.

- A. A health maintenance organization may not expend more than 20% of its total annual health care expenditures for out-of-plan covered services. [1991, c. 709, §5 (NEW).]
- B. If compliance with the amount specified in paragraph A is not demonstrated on a quarterly basis in a health maintenance organization's quarterly financial report, the superintendent may prohibit the health maintenance organization from offering a point-of-service product for new issues or for the renewal of existing contracts until compliance has been demonstrated. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

4. Plan requirements. A health maintenance organization may not issue a point-of-service product until it has filed and has had approved by the superintendent a plan to comply with this section, including, in addition to any other requirements of this section, group contracts, subscriber contracts and other materials used by enrollees.

- A. Marketing materials must be filed upon request of the superintendent. Member handbooks must be filed for approval only when the initial point-of-service plan is filed and when substantial modifications are made in the point-of-service plan that change policy terms respecting benefits or change the manner in which enrollees may access provider services. [1991, c. 709, §5 (NEW).]
- B. The plan must include, but is not limited to, provisions demonstrating that the health maintenance organization will:
 - (1) Design the benefit levels for in-plan covered services and out-of-plan covered services to achieve the desired level of in-plan utilization; and
 - (2) Provide or arrange for the provision of adequate systems to:
 - (a) Process and pay claims for out-of-plan covered services;

(b) Meet the requirements of a point-of-service product as set by this section or by rule of the superintendent; and

(c) Generate accurate financial and regulatory reports on a timely basis in order for the superintendent to evaluate experience with the point-of-service product and monitor compliance with point-of-service product provisions. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

5. Claims processing. Explanation of benefits given to an enrollee of a point-of-service plan must contain an explanation of coverage for self-referral health care services that is adequate to permit an enrollee to determine claims liability under the plan.

[1991, c. 709, §5 (NEW) .]

5-A. Assignment of benefits. All point-of-service contracts and certificates must contain a provision permitting the insured to assign any benefits provided for medical or dental care on an expense-incurred basis to the provider of the care. An assignment of benefits under this subsection does not affect or limit the payment of benefits otherwise payable under the contract or certificate.

[1999, c. 21, §4 (AMD) .]

6. Disclosure. All marketing materials, subscriber contracts, member handbooks or other material used by enrollees must contain a clear and concise explanation of point-of-service health care services. The explanation must include:

A. The method of reimbursement; [1991, c. 709, §5 (NEW).]

B. Applicable copayments and deductibles; [1991, c. 709, §5 (NEW).]

C. Other uncovered costs or charges; [1991, c. 709, §5 (NEW).]

D. The services that an enrollee is permitted to obtain on a self-referral basis; and [1991, c. 709, §5 (NEW).]

E. Instructions regarding submission of claims for self-referred health care services. [1991, c. 709, §5 (NEW).]

[1991, c. 709, §5 (NEW) .]

SECTION HISTORY

1991, c. 709, §5 (NEW). 1997, c. 604, §E4 (AMD). 1999, c. 21, §4 (AMD).

24-A §4208. ANNUAL REPORT

1. Every health maintenance organization shall file annually, on or before March 1st or within any reasonable extension of time that the superintendent for good cause shown may have granted on or before March 1st, with the superintendent a full and true statement of its financial condition, transactions and affairs as of December 31st of the preceding year, verified by at least 3 principal officers and shall provide a copy of that statement to the Commissioner of Human Services. The superintendent may by rule or order require the filing of quarterly or more frequent reports, which may be required to include liability for uncovered expenditures as well as an audit opinion.

[1993, c. 313, §33 (AMD) .]

2.

[1993, c. 313, §34 (RP) .]

3. The annual statement must be prepared in accordance with the National Association of Insurance Commissioners annual statement instructions and must follow practices and procedures prescribed by the National Association of Insurance Commissioners accounting practices and procedures manual for health maintenance organizations. The annual statement must include:

A. A summary of information compiled pursuant to section 4204 in the form required by the Commissioner of Human Services; and [1993, c. 313, §35 (NEW).]

B. Other information related to the performance of the health maintenance organization that is necessary to enable the superintendent to carry out the superintendent's duties under this chapter. [1993, c. 313, §35 (NEW).]

[1993, c. 313, §35 (NEW) .]

4. The superintendent may refuse to continue or may suspend or revoke the certificate of authority of a health maintenance organization failing to file an annual statement when due.

[1993, c. 313, §35 (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §4 (AMD). 1991, c. 709, §6 (AMD).
1993, c. 313, §§33-35 (AMD).

24-A §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 a statement of operations; [1989, c. 842, §15 (NEW).]

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; and [1995, c. 673, Pt. D, §4 (AMD).]

C. [1995, c. 673, Pt. D, §5 (RP).]

D. [1995, c. 673, Pt. D, §5 (RP).]

E. A description of the plan as required under section 4302, subsection 1. [1995, c. 673, Pt. D, §6 (NEW).]

[1995, c. 673, Pt. D, §4-6 (AMD) .]

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

[1989, c. 842, §15 (RPR) .]

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.

[1989, c. 842, §15 (RPR) .]

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.

[1989, c. 842, §15 (RPR) .]

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.

[1989, c. 842, §15 (NEW) .]

6. Notification of cancellation. A health maintenance organization may not cancel or refuse to renew any group contract until it has provided by first class mail at least 10 days' prior notification according to this section. The notice must include the date of cancellation of coverage and the time period for exercising contract conversion rights. The notice also must include an explanation of any applicable grace period. Notification is not required when the health maintenance organization has received written notice from the group contract holder that replacement coverage has been obtained.

A. Notice must be mailed to the group contract holder or subgroup sponsor. [1995, c. 189, §3 (NEW); 1995, c. 189, §4 (AFF).]

B. [2003, c. 156, §5 (RP).]

B-1. At the time of notification under paragraph A, notice must be mailed to the individual enrollee at the last address provided to the health maintenance organization by the subgroup sponsor, the group contract holder or the individual enrollee. If the health maintenance organization does not have an address on file for the individual enrollee, the notice must be mailed to the office of the subgroup sponsor, if any, or the group contract holder. The notice must also include information to the individual enrollee about the availability of individual coverage as described in section 2809-A, subsection 1-B.

[2003, c. 428, Pt. B, §3 (AMD).]

C. [2003, c. 428, Pt. B, §3 (RP).]

[2003, c. 428, Pt. B, §3 (AMD) .]

SECTION HISTORY

1975, c. 503, (NEW). 1989, c. 842, §15 (RPR). 1995, c. 189, §3 (AMD). 1995, c. 673, §§D4-6 (AMD). 1995, c. 189, §4 (AFF). 2003, c. 156, §5 (AMD). 2003, c. 428, §B3 (AMD).

24-A §4210. 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. To the extent not inconsistent with the requirements of chapter 36 and sections 2736-C and 2808-B as qualified by section 4222-B, subsection 3, a health maintenance organization may apply to the superintendent 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 superintendent shall approve or deny the application within 10 days of the receipt of that application from the health maintenance organization.

[1995, c. 332, Pt. O, §4 (AMD) .]

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.

[1975, c. 503, (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW). 1995, c. 332, §04 (AMD).

24-A §4210-A. CONTINUITY OF HEALTH INSURANCE COVERAGE

(REPEALED)

SECTION HISTORY

1989, c. 867, §§9,10 (NEW). 1995, c. 332, §05 (RP).

24-A §4211. COMPLAINT SYSTEM

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

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

2. Each health maintenance organization shall submit to the superintendent and the Commissioner of Health and Human Services an annual report in a form prescribed by the superintendent after consultation with the Commissioner of Health and Human Services that includes:

A. A description of the procedures of such complaint system; [1975, c. 503, (NEW) .]

B. The total number and disposition of complaints handled through the complaint system and a compilation of causes underlying the complaints filed. Complaints concerning access to chiropractic providers and the results of those complaints must be separately identified; and [1993, c. 669, §4 (AMD) .]

C. The number, amount and disposition of malpractice claims settled during the year by the health maintenance organization. [1975, c. 503, (NEW) .]

[2003, c. 2, §87 (COR) .]

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 superintendent a summary report at such times and in such format as the superintendent may require. Such complaints involving other persons shall be referred to such persons with a copy to the superintendent.

[1975, c. 503, (NEW) .]

4. The superintendent and the Commissioner of Health and Human Services may examine such complaint system.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §4 (AMD). 1993, c. 669, §4 (AMD). RR 2003, c. 2, §87 (COR). 2003, c. 689, §B7 (REV).

24-A §4212. 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 chapter:

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 maintenance organization; [1975, c. 503, (NEW).]

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 maintenance organization, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist; [1975, c. 503, (NEW).]

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 maintenance organizations 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 maintenance organization issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage. [1975, c. 503, (NEW).]

[1975, c. 503, (NEW) .]

2. An enrollee may not be cancelled nor denied renewal except for the following:

A. Fraud or material misrepresentation; [1995, c. 332, Pt. O, §6 (NEW).]

B. Failure to pay the charge for coverage; [1995, c. 332, Pt. O, §6 (NEW).]

C. When the provisions of the State's community rating law are applicable, as provided by section 2736-C, subsection 3, paragraph B and section 2808-B, subsection 4, paragraph B; or [1995, c. 332, Pt. O, §6 (NEW).]

D. Other reasons promulgated by the superintendent. [1995, c. 332, Pt. O, §6 (NEW).]

[1995, c. 332, Pt. O, §6 (RPR) .]

3. 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.

[1975, c. 503, (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW). 1995, c. 332, §06 (AMD).

24-A §4213. REGULATION OF AGENTS

The superintendent may, after notice and hearing pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, 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 maintenance organization who engages in solicitation or enrollment. [1977, c. 694, §433 (AMD).]

SECTION HISTORY

1975, c. 503, (NEW). 1977, c. 694, §433 (AMD).

24-A §4214. POWERS OF INSURERS AND NONPROFIT HOSPITAL OR MEDICAL SERVICE CORPORATIONS

1. Subject to the provisions of sections 222, 3479 to 3482 and chapters 13 and 13-A, an insurance company licensed in this State or a nonprofit hospital, medical or health care service organization may establish, maintain, own, merge with, organize and operate a health maintenance organization under this chapter, either directly as a division or line of business, or indirectly through a subsidiary or affiliate. Subject to the provisions of section 222 and chapters 13 and 13-A, 2 or more such insurance companies, or nonprofit hospital, medical or health care service organizations, or subsidiaries or affiliates, may jointly organize and operate a health maintenance organization. The business of an insurer or hospital or medical service corporation that establishes, maintains, owns, merges with, organizes or operates a health maintenance organization is considered to include the providing of health care by a health maintenance organization.

[1993, c. 702, Pt. A, §14 (AMD) .]

1-A. A domestic insurer that establishes, maintains, merges with or organizes and operates a health maintenance organization as a division or line of business is governed in its investment of funds allocated to that line of business by the provisions of section 4204, subsection 3-A.

[1993, c. 702, Pt. A, §15 (NEW) .]

2. Notwithstanding any provision of this Title, an insurer or a nonprofit hospital and medical service corporation 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.

[1975, c. 503, (NEW) .]

3. The enrollees of a health maintenance organization constitute a permissible group, under such laws, and shall not be counted as part of any group for the purposes of chapter 35. Among other things, under such contracts, the insurer or nonprofit hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health maintenance organization.

[1975, c. 503, (NEW) .]

4.

[1989, c. 842, §16 (RP) .]

SECTION HISTORY

1975, c. 503, (NEW). 1989, c. 842, §16 (AMD). 1993, c. 702, §§A14,15 (AMD).

24-A §4215. EXAMINATIONS

1. The superintendent may make an examination of the affairs of any health maintenance organization 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.

[1975, c. 503, (NEW) .]

2. The Commissioner of Health and Human Services may make an examination concerning the quality of health care services of any health maintenance organization 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.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

3. Every health maintenance organization shall submit its books and records relating to health care services to such examinations and in every way facilitate them. For the purpose of examinations, the superintendent and the Commissioner of Health and Human Services may administer oaths to and examine the officers and agents of the health maintenance organization.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

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

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

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

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §4 (AMD). 2003, c. 689, §B7 (REV).

24-A §4216. SUSPENSION OR REVOCATION OF CERTIFICATE OF AUTHORITY

1. Notwithstanding Title 4, chapter 5 and Title 5, section 10051, the superintendent may suspend or revoke a certificate of authority issued to a health maintenance organization under this chapter if the superintendent finds that any of the following conditions exist after a hearing held in accordance with Title 5, chapter 375, subchapter IV:

A. The health maintenance organization is operating significantly in contravention of its basic organizational document 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 superintendent; [1975, c. 503, (NEW) .]

B. The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services that do not comply with the requirements of section 4207; [1997, c. 592, §71 (AMD) .]

C. The health maintenance organization does not provide or arrange for basic health care services; [1975, c. 503, (NEW) .]

D. The Commissioner of Health and Human Services certifies to the superintendent that:

(1) The health maintenance organization does not meet the requirements of section 4204, subsection 2-A, paragraph B; or

(2) The health maintenance organization is unable to fulfill its obligations to furnish health care services; [1997, c. 683, Pt. B, §14 (AMD); 2003, c. 689, Pt. B, §7 (REV).]

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; [1975, c. 503, (NEW).]

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; [1975, c. 503, (NEW).]

G. The health maintenance organization has failed to implement the complaint system required by section 4211 in a manner to reasonably resolve valid complaints; [1975, c. 503, (NEW).]

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; [1975, c. 503, (NEW).]

I. The continued operation of the health maintenance organization would be hazardous to its enrollees; [1975, c. 503, (NEW).]

I-1. The health maintenance organization has failed to meet the surplus requirements of section 4204-A; or [1989, c. 842, §17 (NEW).]

J. The health maintenance organization has otherwise failed to substantially comply with this chapter. [1975, c. 503, (NEW).]

[1999, c. 547, Pt. B, §46 (AMD); 1999, c. 547, Pt. B, §80 (AFF); 2003, c. 689, Pt. B, §7 (REV) .]

2. A certificate of authority shall be suspended or revoked only after compliance with the requirements of section 4219.

[1975, c. 503, (NEW) .]

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.

[1975, c. 503, (NEW) .]

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 superintendent 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.

[1975, c. 503, (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §4 (AMD). 1977, c. 694, §434 (AMD). 1989, c. 842, §17 (AMD). 1997, c. 592, §71 (AMD). 1997, c. 683, §B14 (AMD). 1999, c. 547, §B46 (AMD). 1999, c. 547, §B80 (AFF). 2003, c. 689, §B7 (REV).

24-A §4217. REHABILITATION, LIQUIDATION OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATIONS

Any rehabilitation, liquidation or conservation of 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 superintendent pursuant to the laws governing the rehabilitation, liquidation or conservation of insurance companies. The superintendent may institute summary proceedings in the same manner as provided in the laws governing delinquent insurers, and he may apply for an order directing him to rehabilitate, liquidate or conserve a health maintenance organization when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State. [1975, c. 503, (NEW).]

SECTION HISTORY

1975, c. 503, (NEW).

24-A §4218. REGULATIONS

The superintendent may, after notice and hearing pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, promulgate reasonable rules and regulations as are necessary or proper to carry out this chapter. Such rules and regulations shall be subject to review in accordance with sections 229 to 236. [1977, c. 694, §435 (AMD).]

SECTION HISTORY

1975, c. 503, (NEW). 1977, c. 694, §435 (AMD).

24-A §4219. ADMINISTRATIVE PROCEDURES

1. When the superintendent has cause to believe that grounds exist for the suspension or revocation of a certificate of authority, the superintendent shall notify the health maintenance organization and the Commissioner of Health and Human Services in writing specifically stating the grounds for suspension or revocation. The Commissioner of Health and Human Services, or the commissioner's designated representative, shall participate in any disciplinary proceedings. In the process of determining whether grounds for suspension or revocation exist the findings of the commissioner with respect to matters relating to the quality of health care services provided are conclusive and binding upon the Superintendent of Insurance. The duration of and conditions attached to any suspension are determined by the superintendent after a hearing held in accordance with Title 5, chapter 375, subchapter IV.

[1997, c. 592, §72 (AMD); 2003, c. 689, Pt. B, §7 (REV) .]

2. The Superintendent of Insurance, acting in concert with the Commissioner of Health and Human Services, has the authority to amend, modify or refuse to renew any certificate of authority for cause, pursuant to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV.

[1977, c. 694, §436 (RPR); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY

1975, c. 503, (NEW). 1977, c. 694, §436 (RPR). 1997, c. 592, §72 (AMD). 2003, c. 689, §B7 (REV).

24-A §4220. FEES

1. Every health maintenance organization subject to this chapter shall pay to the superintendent the following fees:

- A. For filing an initial application for a certificate of authority, \$500; [1975, c. 503, (NEW).]
- B. For filing each annual report, \$50. [1975, c. 503, (NEW).]

[1975, c. 503, (NEW) .]

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

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §4 (AMD). 2003, c. 689, §B7 (REV).

24-A §4221. PENALTIES AND ENFORCEMENT

1. The superintendent may 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 superintendent 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.

[1977, c. 694, §437 (AMD) .]

2. If the superintendent or the Commissioner of Health and Human Services shall for any reason have cause to believe that any violation of this chapter has occurred or is threatened, the superintendent or Commissioner of Health and Human Services 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 superintendent or the Commissioner of Health and Human Services may deem appropriate under the circumstances.

[1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

3. The superintendent 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 chapter.

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 chapter have occurred.

[1975, c. 503, (NEW) .]

4. In the case of any violation under this chapter, if the superintendent 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 superintendent may apply to the Superior Court to issue an injunction restraining the company in whole or in part from proceeding further with its business, or he may apply for an order of the court to command performance consistent with contractual obligations of the health maintenance organization.

[1975, c. 503, (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §5 (AMD). 1977, c. 694, §437 (AMD). 2003, c. 689, §B7 (REV).

24-A §4222. STATUTORY CONSTRUCTION AND RELATIONSHIP TO OTHER LAWS

1. Except as otherwise specifically provided, provisions of the insurance law and the laws relating to hospital or medical service corporations do not apply to a health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws of this State except with respect to its health maintenance organization activities, whether those activities are conducted through a subsidiary or as a division or line of business, authorized and regulated pursuant to this chapter.

[1993, c. 702, Pt. A, §16 (AMD) .]

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.

[1975, c. 503, (NEW) .]

3. Any health maintenance organization authorized under this chapter is not deemed to be practicing medicine and is exempt from provisions of law relating to the practice of medicine, except that this subsection may not be asserted by a health maintenance organization as a defense to any action brought by an enrollee pursuant to section 4313.

[1999, c. 742, §1 (AMD) .]

4.

[1995, c. 625, Pt. A, §26 (RP) .]

SECTION HISTORY

1975, c. 503, (NEW). 1991, c. 861, §3 (AMD). 1991, c. 861, §4 (AFF). 1993, c. 702, §A16 (AMD). 1995, c. 332, §§L2,07 (AMD). 1995, c. 625, §A26 (AMD). 1999, c. 742, §1 (AMD).

24-A §4222-A. RULES

Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent may make, adopt, amend and rescind reasonable rules to aid the administration or effectuation of any provisions of this chapter. [1993, c. 702, Pt. A, §17 (NEW) .]

SECTION HISTORY

1993, c. 702, §A17 (NEW) .

24-A §4222-B. APPLICABILITY

1. Every health maintenance organization licensed under this chapter is considered an insurer for purposes of those provisions of the insurance laws that do not expressly reference health maintenance organizations, but are applicable to health maintenance organizations under this chapter.

[1995, c. 332, Pt. O, §8 (NEW) .]

2. The requirements of chapter 36, continuity of health insurance coverage law, apply to health maintenance organizations.

[1995, c. 332, Pt. O, §8 (NEW) .]

3. The requirements of sections 2736-C and 2808-B, community rating law, apply to health maintenance organizations, except that a health maintenance organization is not required to offer coverage or accept applications from an eligible group or individual located outside the health maintenance organization's approved service area.

[1995, c. 332, Pt. O, §8 (NEW) .]

4. The requirements of chapter 23 and any rules adopted pursuant to it, to the extent not inconsistent with this chapter and the reasonable implications of this chapter, apply to health maintenance organizations.

[1995, c. 332, Pt. O, §8 (NEW) .]

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.

[2001, c. 88, §6 (AMD) .]

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

[2001, c. 88, §6 (AMD) .]

7. The requirements of section 421 apply to health maintenance organizations.

[1997, c. 457, §50 (AMD) .]

8. The requirements of chapter 32, the Preferred Provider Arrangement Act of 1986, apply to health maintenance organizations only with respect to activities that are not otherwise authorized by chapter 56.

[1995, c. 332, Pt. O, §8 (NEW) .]

9. The requirements of chapter 56-A and any rules adopted pursuant to that chapter apply to health maintenance organizations.

[1995, c. 673, Pt. D, §7 (NEW) .]

10. The requirements of section 237 apply to health maintenance organizations, including those operated and organized as a division or line of business of a nonprofit hospital, medical or health care service organization.

[1997, c. 79, §3 (NEW) .]

11. The requirements of sections 2834 and 2834-B apply to health maintenance organizations.

[1997, c. 445, §31 (NEW); 1997, c. 445, §32 (AFF) .]

12. The requirements of chapter 24 and any rules adopted pursuant to that chapter apply to health maintenance organizations.

[1997, c. 677, §4 (NEW) .]

13. The requirements of sections 2436 and 2436-A apply to health maintenance organizations.

[1999, c. 256, Pt. F, §1 (NEW) .]

14. The requirement of filing a report of experience of claims payment for alcoholism and drug dependency treatment in the format prescribed by section 2842, subsection 9; for chiropractic services in the format prescribed by section 2748, subsection 3 and section 2840-A, subsection 3; and for breast cancer screening services in the format prescribed by section 2745-A, subsection 4 and section 2837-A, subsection 4 applies to health maintenance organizations.

[2001, c. 258, Pt. G, §3 (AMD) .]

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

[2001, c. 88, §7 (NEW) .]

15. (REALLOCATED TO T. 24-A, §4222-B, sub-§20)

[2001, c. 1, §35 (RAL) .]

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

[2001, c. 88, §7 (NEW) .]

17. Section 2803-A, relating to disclosure of loss information, applies to health maintenance organizations.

[2001, c. 410, Pt. B, §3 (NEW) .]

18. The requirement of section 2809-A, subsection 11 to continue group coverage under certain circumstances applies to health maintenance organizations.

[2001, c. 410, Pt. B, §3 (NEW) .]

19. Section 12-A, relating to penalties, applies to health maintenance organizations.

[2001, c. 410, Pt. B, §3 (NEW) .]

20. (REALLOCATED FROM T. 24-A, §4222-B, sub-§15) Sections 2735-A and 2839-A, relating to notice of rate filings and rate increases, apply to health maintenance organizations.

[2001, c. 1, §35 (RAL) .]

21. Section 2723-A, subsection 3 and section 2844, subsection 3 apply to health maintenance organizations.

[2005, c. 121, Pt. D, §4 (NEW) .]

22. Sections 2713-A and 2823-A, relating to explanation and notice to parents, apply to health maintenance organizations.

[2009, c. 244, Pt. B, §3 (NEW) .]

SECTION HISTORY

1995, c. 332, §08 (NEW). 1995, c. 673, §D7 (AMD). 1997, c. 79, §3 (AMD). 1997, c. 445, §31 (AMD). 1997, c. 457, §50 (AMD). 1997, c. 677, §4 (AMD). 1997, c. 445, §32 (AFF). 1999, c. 256, §F1 (AMD). 2001, c. 88, §§6,7 (AMD). 2001, c. 258, §G3 (AMD). 2001, c. 410, §B3 (AMD). 2001, c. 432, §8 (AMD). RR 2001, c. 1, §35 (COR). 2005, c. 121, §D4 (AMD). 2009, c. 244, Pt. B, §3 (AMD).

24-A §4223. FILINGS AND REPORTS AS PUBLIC DOCUMENTS

All applications, filings and reports required under this chapter shall be treated as public documents subject to limitations and exceptions provided in Title 1, chapter 13, subchapter I. [1985, c. 704, §7 (AMD) .]

SECTION HISTORY

1975, c. 503, (NEW). 1985, c. 704, §7 (AMD).

24-A §4224. CONFIDENTIALITY; LIABILITY; ACCESS TO RECORDS

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

[1991, c. 709, §7 (NEW) .]

2. Liability. A person who, in good faith and without malice, as a member, agent or employee of a quality assurance committee, assists in the origination, investigation or preparation of a report or information related to treatment previously rendered, submits that report or information to a health maintenance organization or appropriate state licensing board, or assists the committee in carrying out any of its duties under this chapter is not subject to civil liability for damages as a consequence of those actions, nor is the health maintenance organization that established that committee or the officers, directors, employees or agents of that health maintenance organization liable for the activities of that person. This section may not be construed to relieve any person of liability arising from treatment of a patient.

A. The information considered by a quality assurance committee and the records of its actions and proceedings are confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal, if permitted, from the findings or recommendations of the committee. A member of a quality assurance committee or an officer, director, staff person or other member of a health maintenance organization engaged in assisting the committee or any person assisting or furnishing information to the committee may not be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on these activities. [1991, c. 709, §7 (NEW).]

B. Information considered by a quality assurance committee and the records and proceedings of that committee used pursuant to paragraph A by a state licensing or certifying agency or in an appeal must be kept confidential and are subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of the health care review committee. [1991, c. 709, §7 (NEW).]

[1991, c. 709, §7 (NEW) .]

3. Access to records. To fulfill the obligations of a health maintenance organization under section 4204, subsection 2-A, paragraph B, a health maintenance organization must have access to treatment records and other information pertaining to the diagnosis, treatment and health status of any enrollee.

[1991, c. 709, §7 (NEW) .]

SECTION HISTORY

1975, c. 503, (NEW). 1991, c. 709, §7 (RPR).

24-A §4224-A. LOSS INFORMATION

(REPEALED)

SECTION HISTORY

1995, c. 71, §3 (NEW). 1997, c. 370, §E7 (AMD). 2001, c. 410, §B4 (RP).

24-A §4225. COMMISSIONER OF HEALTH AND HUMAN SERVICE'S AUTHORITY TO CONTRACT

The Commissioner of Health and Human Services, in carrying out his obligations under sections 4204, subsection 1, paragraph B, 4215 and 4216, 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 Human Services. [1975, c. 503, (NEW); 2003, c. 689, Pt. B, §7 (REV).]

SECTION HISTORY

1975, c. 503, (NEW). 1975, c. 293, §4 (AMD). 2003, c. 689, §B7 (REV).

24-A §4226. FEDERAL LEGISLATION

Nothing in this chapter shall prohibit any health maintenance organization from meeting the requirements of any federal law which would authorize such health maintenance organization to receive federal financial assistance or certification or to enroll beneficiaries assisted by federal funds. [1975, c. 503, (NEW).]

SECTION HISTORY

1975, c. 503, (NEW).

24-A §4227. CHOICE OF ALTERNATIVE COVERAGE

Any employer of more than 50 employees who offers a health maintenance organization, as defined in section 4202-A, shall also offer its employees, at the time of offering and renewal of the health maintenance organization, the option of selecting alternative health benefits coverage that does not restrict the ability of the covered persons to obtain health care services from the providers of their choice. [1991, c. 709, §8 (AMD).]

Any employer subject to this section shall contribute to the alternative health benefits coverage to the same extent as it contributes to the health maintenance organization. [1985, c. 704, §8 (NEW).]

An employer may not be required to pay more for health benefits as a result of the application of this section than would otherwise be paid. [1991, c. 709, §8 (AMD).]

An employer may satisfy the requirements of this section by offering a point-of-service option but may not satisfy the requirements of this section by contributing to the cost of an individual health plan. [1997, c. 370, Pt. B, §4 (AMD).]

SECTION HISTORY

1985, c. 704, §8 (NEW). 1991, c. 709, §8 (AMD). 1997, c. 370, §B4 (AMD).

24-A §4228. UTILIZATION REVIEW DATA

1. Report required. On or before April 1st of each year, each health maintenance organization which issues a program of contract in this State that contains a provision whereby in nonemergency cases the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed or ordered by a duly licensed physician shall file a report on the results of that evaluation for the preceding year with the superintendent which shall contain the following:

A. The number and type of evaluations performed.

(1) For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service.

(2) The report must separately identify the number of evaluations performed in which the health care services requested or provided include chiropractic services and the results of those evaluations; [1993, c. 669, §5 (AMD).]

B. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or whether benefits paid for the service were reduced by the health maintenance organization; [1987, c. 168, §5 (NEW).]

C. The number and result of any appeals by patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and [1987, c. 168, §5 (NEW).]

D. Any complaints filed in a court of competent jurisdiction and served upon a health maintenance organization filing under this section stating a cause of action against that organization on the basis of damages to patients alleged to have been proximately caused by a delay, reduction or denial of medical benefits by the organization, as determined through prospective evaluations, and the determination of liability or other disposition of the complaint. [1987, c. 168, §5 (NEW).]

[1993, c. 669, §5 (AMD) .]

2. Maine residents. This section is applicable to evaluations, appeals and complaints relating to Maine residents only.

[1987, c. 168, §5 (NEW) .]

3. Confidentiality. Any information provided pursuant to this section shall not identify the names of patients.

[1987, c. 168, §5 (NEW) .]

SECTION HISTORY

1987, c. 168, §5 (NEW). 1993, c. 669, §5 (AMD).

24-A §4229. ACQUIRED IMMUNE DEFICIENCY SYNDROME

No policy, contract or certificate delivered or issued for delivery in this State may provide more restrictive coverage for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex or HIV related diseases than for any other disease or sickness or exclude coverage for AIDS, ARC or HIV related diseases except through an exclusion under which all sicknesses and diseases are treated the same. [1989, c. 176, §9 (NEW).]

SECTION HISTORY

1989, c. 176, §9 (NEW).

24-A §4230. TRADE PRACTICES AND FRAUDS

(REPEALED)

SECTION HISTORY

1989, c. 345, §2 (NEW). 1995, c. 332, §09 (RP).

24-A §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.

[2001, c. 88, §8 (AMD) .]

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.

[1989, c. 842, §18 (NEW) .]

3. Nongroup enrollees.

[1995, c. 332, Pt. O, §10 (RP) .]

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.

[2001, c. 88, §9 (NEW) .]

SECTION HISTORY

1989, c. 842, §18 (NEW). 1995, c. 332, §010 (AMD). 2001, c. 88, §§8,9 (AMD).

24-A §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.

[1989, c. 842, §18 (NEW) .]

2. Preexisting conditions. No provision in a succeeding insurer's or nonprofit hospital or medical service corporation's contract of replacement coverage may reduce or exclude benefits to enrollees covered under the prior health maintenance organization's contract on the date of discontinuance, on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding contract, except to the extent that benefits for the condition would have been reduced or excluded under the prior contract.

[1989, c. 842, §18 (NEW) .]

SECTION HISTORY

1989, c. 842, §18 (NEW).

24-A §4233. REGISTRATION, REGULATION AND SUPERVISION OF HOLDING COMPANY SYSTEMS

1.

[1995, c. 332, Pt. O, §11 (RP) .]

2. Every domestic health maintenance organization is subject to the requirements of section 221-A. At the superintendent's request, a domestic health maintenance organization must make available to the superintendent the audit work papers of any accountant who has audited that health maintenance organization.

Upon timely notice to a health maintenance organization, the superintendent may review, photocopy or otherwise record the audit work papers generated by any accountant who has audited that health maintenance organization.

Health maintenance organization work papers under the superintendent's custody or control are confidential and not subject to public inspection.

The work papers of a health maintenance organization's parent, subsidiaries or other corporate affiliates are deemed to be the work papers of that health maintenance organization to the extent the work papers affect the health maintenance organization's final equity determination and reference any transaction between the health maintenance organization and its parent, subsidiaries or corporate affiliates.

As a condition of engaging an auditing accountant, the health maintenance organization shall require the accountant to:

- A. Retain for a period of at least 6 years any work papers prepared in connection with the accountant's audit of that health maintenance organization; and [1993, c. 313, §36 (NEW).]
- B. Provide, at the request of the health maintenance organization, the original or copies of any work papers created by the accountant in connection with an audit of that health maintenance organization. [1993, c. 313, §36 (NEW).]

For purposes of this subsection, the term "work papers" includes, but is not limited to, originals or copies of any schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, company records or other documents prepared or obtained by the accountant and the accountant's employees in the course of conducting an audit of the health maintenance organization.

[1993, c. 313, §36 (NEW) .]

SECTION HISTORY

1989, c. 842, §18 (NEW). 1993, c. 313, §36 (RPR). 1995, c. 332, §011 (AMD).

24-A §4233-A. EXTENSION OF COVERAGE FOR DEPENDENT CHILDREN

An individual or group health maintenance organization contract that provides coverage for a dependent child at certain ages only if the child is a student must continue that coverage if the child is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or an accidental injury. This coverage may be terminated at the age at which coverage for students terminates under the terms of the contract. A health maintenance organization may require, as a condition of eligibility for continued coverage in accordance with this section, that the student provide written documentation from a health care provider and the student's school that the student is no longer enrolled in school on a full-time basis due to a mental or physical illness or accidental injury. [2007, c. 115, §3 (AMD); 2007, c. 115, §5 (AFF).]

SECTION HISTORY

2007, c. 115, §3 (AMD). 2007, c. 115, §5 (AFF).

24-A §4233-B. MANDATORY OFFER TO EXTEND COVERAGE FOR DEPENDENT CHILDREN UP TO 25 YEARS OF AGE

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

1. Dependent child; definition. As used in this section, "dependent child" means the child of a person covered under an individual or group health maintenance organization contract when that child:

- A. Is unmarried; [2007, c. 115, §4 (NEW); 2007, c. 115, §5 (AFF).]
- B. Has no dependent of the child's own; and [2007, c. 514, §11 (AMD).]
- C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education. [2007, c. 514, §12 (AMD).]
- D. [2007, c. 514, §13 (RP).]

[2007, c. 514, §§11-13 (AMD) .]

2. Offer of coverage. An individual or group health maintenance organization contract that offers coverage for a dependent child shall offer such coverage, at the option of the contract holder, until the dependent child is 25 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

[2007, c. 514, §14 (AMD) .]

3. (TEXT EFFECTIVE UNTIL 1/1/12) Notice. A health maintenance organization shall provide notice to contract holders regarding the availability of dependent coverage under this section upon each renewal of coverage or at least once annually, whichever occurs more frequently. Notice provided under this subsection must include information about enrollment periods and notice of the insurer's definition of and benefit limitations for preexisting conditions.

This subsection is repealed January 1, 2012.

[2007, c. 514, §15 (NEW) .]

SECTION HISTORY

2007, c. 115, §4 (NEW). 2007, c. 514, §§11-15 (AMD). 2007, c. 115, §5 (AFF) .

24-A §4234. CHILD COVERAGE

1. Definitions. For the purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the enrollee, member or spouse of the enrollee or member. [1993, c. 666, Pt. A, §7 (NEW) .]

B. "Placed for adoption" means the assumption and retention of a legal obligation by a person for the total or partial support of a child in anticipation of adoption of the child. If the legal obligation ceases to exist, the child is no longer considered placed for adoption. [1993, c. 666, Pt. A, §7 (NEW) .]

[1993, c. 666, Pt. A, §7 (RPR) .]

2. Coverage. All individual or group coverage subject to this chapter must provide unmarried enrollees with the same benefits or option of benefits for dependent children as is extended to dependent children of married enrollees, at appropriate rates and under the same terms and conditions.

[1991, c. 200, Pt. B, §5 (NEW) .]

3. Financial dependency. Financial dependency of dependent children on the enrollee or the spouse of the enrollee may not be required as a condition for eligibility for coverage.

[1991, c. 200, Pt. B, §5 (NEW) .]

4. Adopted children. All individual or group contracts issued in accordance with the requirements of this section must provide the same benefits to dependent children placed for adoption with the enrollee or spouse of the enrollee under the same terms and conditions as apply to natural dependent children or stepchildren of the enrollee or spouse of the enrollee, irrespective of whether the adoption has become final.

[1993, c. 666, Pt. A, §8 (NEW) .]

5. Medicaid. Health maintenance organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," when considering coverage eligibility or benefit calculations for enrollees and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the enrollee or family member to payment by the health maintenance organization for those health care items or services. Upon presentation of proof that the Medicaid program has paid for covered items or services, the health maintenance organization shall make payment to the Medicaid program according to the coverage provided in the contract or certificate. [1993, c. 666, Pt. B, §3 (NEW).]

B. A health maintenance organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid and covered by an enrollee contract that are different from requirements applicable to an agent or assignee of any other covered individual. [1993, c. 666, Pt. B, §3 (NEW).]

[1993, c. 666, Pt. B, §3 (NEW) .]

SECTION HISTORY

1991, c. 200, §B5 (NEW). 1993, c. 666, §§A7,8,B3 (AMD).

24-A §4234-A. MENTAL HEALTH SERVICES COVERAGE

1. Findings. The Legislature finds that:

A. Mental illness affects nearly 170,000 people of this State each year, resulting in anguish, grief, desperation, fear, isolation and a sense of hopelessness of significant levels among victims and families; [1995, c. 407, §10 (NEW).]

B. Consequences of mental illness include the expenditure of millions of dollars of public funds for treatment and losses of millions of dollars by businesses in the State in accidents, absenteeism, nonproductivity and turnover. Excessive stress and anxiety and other forms of mental illness clearly contribute to general health problems and costs; [1995, c. 407, §10 (NEW).]

C. Typical health coverage in this State discriminates against mental illness, the victims and affected families with nonexistent or limited benefits compared to provisions for other illnesses; and [1995, c. 407, §10 (NEW).]

D. Experience in this State and several other states demonstrates that the risk of mental illness can be insured at reasonable cost and with adequate controls on quality and utilization of treatment. [1995, c. 407, §10 (NEW).]

[1995, c. 407, §10 (NEW) .]

2. Policy and purpose. The Legislature declares that it is the policy of this State to:

A. Promote equitable and nondiscriminatory health coverage benefits for all forms of illness including mental and emotional disorders that are of significant consequence to the health of people of the State and that can be treated in a cost-effective manner; [1995, c. 407, §10 (NEW).]

B. Ensure that victims of mental and other illnesses have access to and choice of appropriate treatment at the earliest point of illness in the least restrictive settings; [1995, c. 407, §10 (NEW).]

C. Ensure that costs of treatment of mental illness are supported through an equitable combination of public and private responsibilities; and [1995, c. 407, §10 (NEW).]

D. Ensure that the Legislature reasonably exercises its legal responsibility for insurance policy in this State by prescribing types of illnesses and treatment for which benefits must be provided. [1995, c. 407, §10 (NEW).]

[1995, c. 407, §10 (NEW) .]

3. Definitions. For purposes of this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Day treatment services" includes psychoeducational, physiological, psychological and psychosocial concepts, techniques and processes necessary to maintain or develop functional skills of clients, provided to individuals and groups for periods of more than 2 hours but less than 24 hours a day. [1995, c. 407, §10 (NEW).]

A-1. "Diagnostic and Statistical Manual" means the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association. [2003, c. 20, Pt. VV, §16 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

A-2. "Home health care services" means those services rendered by a licensed provider of mental health services to provide medically necessary health care to a person suffering from a mental illness in the person's place of residence if:

- (1) Hospitalization or confinement in a residential treatment facility would otherwise have been required if home health care services were not provided;
- (2) Hospitalization or confinement in a residential treatment facility is not required as an antecedent to the provision of home health care services; and
- (3) The services are prescribed in writing by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [2003, c. 20, Pt. VV, §16 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. "Inpatient services" includes a range of physiological, psychological and other intervention concepts, techniques and processes used in a community mental health psychiatric inpatient unit, general hospital psychiatric unit or psychiatric hospital licensed by the Department of Human Services or in an accredited public hospital to restore psychosocial functioning sufficient to allow maintenance and support of the client in a less restrictive setting. [1995, c. 407, §10 (NEW).]

B-1. "Medically necessary health care" has the same meaning as in section 4301-A, subsection 10-A. [2003, c. 20, Pt. VV, §17 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

C. "Outpatient services" includes screening, evaluation, consultations, diagnosis and treatment involving use of psychoeducational, physiological, psychological and psychosocial evaluative and interventive concepts, techniques and processes provided to individuals and groups. [1995, c. 407, §10 (NEW).]

D. "Person suffering from a mental illness" means a person whose psychobiological processes are impaired severely enough to manifest problems in the area of social, psychological or biological functioning. Such a person has a disorder of thought, mood, perception, orientation or memory that impairs judgment, behavior, capacity to recognize or ability to cope with the ordinary demands of life. The person manifests an impaired capacity to maintain acceptable levels of functioning in the area of intellect, emotion or physical well-being. [2003, c. 20, Pt. VV, §18 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

E. "Provider" means an individual included in section 2744, subsection 1, a licensed physician, an accredited public hospital or psychiatric hospital or a community agency licensed at the comprehensive service level by the Department of Health and Human Services. All agency or institutional providers

named in this paragraph shall ensure that services are supervised by a psychiatrist or licensed psychologist. [1999, c. 256, Pt. O, §3 (AMD); 2001, c. 354, §3 (AMD); 2003, c. 689, Pt. B, §6 (REV).]

[2003, c. 20, Pt. VV, §§16-18 (AMD); 2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

4. Requirement. Every health maintenance organization that issues individual or group health care contracts providing coverage to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for conditions arising from mental illness.

[2003, c. 20, Pt. VV, §19 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

5. Services. Each individual or group contract must provide for medically necessary health care for a person suffering from mental illness. Medically necessary health care includes, but is not limited to, the following services for a person suffering from a mental illness:

A. Inpatient services; [1995, c. 407, §10 (NEW).]

B. Day treatment services; [2003, c. 20, Pt. VV, §19 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

C. Outpatient services; and [2003, c. 20, Pt. VV, §19 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

D. Home health care services. [2003, c. 20, Pt. VV, §19 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

[2003, c. 20, Pt. VV, §19 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

6. Coverage for treatment of certain mental illnesses. Coverage for medical treatment for mental illnesses listed in paragraph A-1 is subject to this subsection.

A. [2003, c. 20, Pt. VV, §25 (AFF); 2003, c. 20, Pt. VV, §20 (RP).]

A-1. All group contracts must provide, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following categories of mental illness as defined in the Diagnostic and Statistical Manual, except for those designated as "V" codes in the Diagnostic and Statistical Manual:

- (1) Psychotic disorders, including schizophrenia;
- (2) Dissociative disorders;
- (3) Mood disorders;
- (4) Anxiety disorders;
- (5) Personality disorders;
- (6) Paraphilias;
- (7) Attention deficit and disruptive behavior disorders;
- (8) Pervasive developmental disorders;
- (9) Tic disorders;
- (10) Eating disorders, including bulimia and anorexia; and
- (11) Substance abuse-related disorders.

For the purposes of this paragraph, the mental illness must be diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness. [2003, c. 20, Pt. VV, §20 (NEW); 2003, c. 20, Pt. VV, §25 (AFF).]

B. All policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must provide benefits that meet the requirements of this paragraph.

- (1) The contracts must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.
- (2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the group contract.
- (3) If benefits and coverage for the treatment of physical illness are provided on an expense-incurred basis, the benefits and coverage required under this subsection may be delivered separately under a managed care system.
- (4) A policy or contract may not have separate maximums for physical illness and mental illness, separate deductibles and coinsurance amounts for physical illness and mental illness, separate out-of-pocket limits in a benefit period of not more than 12 months for physical illness and mental illness or separate office visit limits for physical illness and mental illness.
- (5) A health benefit plan may not impose a limitation on coverage or benefits for mental illness unless that same limitation is also imposed on the coverage and benefits for physical illness covered under the policy or contract.
- (6) Copayments required under a policy or contract for benefits and coverage for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance required under the policy or contract for a benefit or coverage for a physical illness.
- (7) For the purposes of this section, a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for the treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits. [2003, c. 20, Pt. VV, §20 (AMD); 2003, c. 20, Pt. VV, §25 (AFF).]

This subsection does not apply to policies, contracts or certificates covering employees of employers with 20 or fewer employees, whether the group policy is issued to the employer, to an association, to a multiple-employer trust or to another entity.

[2003, c. 20, Pt. VV, §20 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

7. Mandated offer of coverage for certain mental illnesses. Except as provided in subsection 6, coverage for medical treatment for mental illnesses listed in paragraph A by all individual and group contracts is subject to this subsection.

A. All individual and group contracts must make available coverage providing, at a minimum, benefits according to paragraph B, subparagraph (1) for a person receiving medical treatment for any of the following mental illnesses diagnosed by a licensed allopathic or osteopathic physician or a licensed psychologist who is trained and has received a doctorate in psychology specializing in the evaluation and treatment of mental illness:

- (1) Schizophrenia;
- (2) Bipolar disorder;

- (3) Pervasive developmental disorder, or autism;
- (4) Paranoia;
- (5) Panic disorder;
- (6) Obsessive-compulsive disorder; or
- (7) Major depressive disorder. [2003, c. 20, Pt. VV, §21 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

B. All individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State must make available coverage providing benefits that meet the requirements of this paragraph.

(1) The offer of coverage must provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses.

(2) At the request of a reimbursing health maintenance organization, a provider of medical treatment for mental illness shall furnish data substantiating that initial or continued treatment is medically necessary health care. When making the determination of whether treatment is medically necessary health care, the provider shall use the same criteria for medical treatment for mental illness as for medical treatment for physical illness under the individual or group contract. [2003, c. 20, Pt. VV, §21 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

[2003, c. 20, Pt. VV, §21 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

8. Contracts; providers. A health maintenance organization incorporated under this chapter shall allow providers, pursuant to sections 2744 and 2835, to contract for and receive payment, subject to the health maintenance organization's credentialing policy, for the provision of mental health services within the scope of the provider's licensure.

[2003, c. 65, §3 (AMD); 2003, c. 65, §5 (AFF) .]

8-A. Mental health services provided by counseling professionals. A health maintenance organization that issues individual or group health care contracts providing coverage for mental health services shall offer coverage for those services when performed by a counseling professional who is licensed by the State pursuant to Title 32, chapter 119 to assess and treat interpersonal and intrapersonal problems, has at least a master's degree in counseling or a related field from an accredited educational institution and has been employed as counselor for at least 2 years. Any contract providing coverage for the services of counseling professionals pursuant to this subsection may be subject to any reasonable limitations, maximum benefits, coinsurance, deductibles or exclusion provisions applicable to overall benefits under the contract.

[2003, c. 20, Pt. VV, §23 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

9. Limits; coinsurance; deductibles. A policy or contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1995, c. 407, §10 (NEW) .]

10. Reports to the superintendent. Every health maintenance organization subject to this section shall report its experience for each calendar year to the superintendent no later than April 30th of the following year. The report must be in a form prescribed by the superintendent and include the amount of claims paid in this State for the services required by this section and the total amount of claims paid in this State for

individual and group health care contracts, both separated according to those paid for inpatient, day treatment and outpatient services. The superintendent shall compile this data for all health maintenance organizations in an annual report.

[1995, c. 407, §10 (NEW) .]

11. Application. Except as otherwise provided, the requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. Contracts entered into with the State Government or the Federal Government to service Medicaid or Medicare populations may limit the services provided under such contracts consistent with the terms of those contracts if mental health services are provided to these populations by other means.

[2003, c. 20, Pt. VV, §24 (AMD); 2003, c. 20, Pt. VV, §25 (AFF) .]

SECTION HISTORY

1995, c. 407, §10 (NEW). 1995, c. 560, §K82 (AMD). 1995, c. 637, §§6,7 (AMD). 1995, c. 673, §D8 (AMD). 1995, c. 560, §K83 (AFF). 1997, c. 174, §1 (AMD). 1999, c. 256, §O3 (AMD). 2001, c. 354, §3 (AMD). 2003, c. 20, §§VV16-24 (AMD). 2003, c. 65, §3 (AMD). 2003, c. 20, §VV25 (AFF). 2003, c. 65, §5 (AFF). 2003, c. 689, §B6 (REV).

24-A §4234-B. MATERNITY AND ROUTINE NEWBORN CARE

Individual and group contracts and certificates issued by a health maintenance organization that provide maternity benefits, including benefits for childbirth, shall provide coverage for services related to maternity and routine newborn care, including coverage for hospital stay, in accordance with the attending physician's or attending certified nurse midwife's determination in conjunction with the mother that the mother and newborn meet the criteria outlined in the "Guidelines for Perinatal Care," published by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. For the purposes of this section, "routine newborn care" does not include any services provided after the mother has been discharged from the hospital. For the purposes of this section, "attending physician" includes the obstetrician, pediatrician or other physician attending the mother and newborn. Benefits for routine newborn care required by this section are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the deductible, coinsurance and copayments for coverage required by this section. [2003, c. 517, Pt. B, §23 (AMD) .]

SECTION HISTORY

1995, c. 615, §4 (NEW). 2001, c. 258, §A4 (AMD). 2003, c. 517, §B23 (AMD) .

24-A §4234-C. NEWBORN CHILDREN COVERAGE

All individual and group health maintenance organization contracts must provide that benefits are payable with respect to a newly born child from the moment of birth. [1997, c. 604, Pt. C, §4 (NEW) .]

The coverage for newly born children must consist of coverage of injury, sickness or other benefits provided by the contract, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. [1997, c. 604, Pt. C, §4 (NEW) .]

If payment of a specific premium or subscription fee is required to provide coverage for a child, the contract may require that notification of birth of a newly born child and payment of the required fees must be furnished to the nonprofit hospital or medical service organization within 31 days after the date of birth in order to have the coverage continue beyond that 31-day period. The payment may be required to be retroactive to the date of birth. Benefits required by section 4234-B must be paid regardless of whether coverage under this section is elected. [1997, c. 604, Pt. C, §4 (NEW) .]

The requirements of this section apply to all contracts delivered or issued for delivery in this State on or after the effective date of this Act. [1997, c. 604, Pt. C, §4 (NEW).]

SECTION HISTORY

1997, c. 604, §C4 (NEW).

24-A §4234-D. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR CANCER

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

- A. "Medically accepted indication" includes any use of a drug that has been approved by the federal Food and Drug Administration and includes another use of the drug if that use is supported by one or more citations in the standard reference compendia or if the health maintenance organization involved, based upon guidance provided by the federal Department of Health and Human Services Medicare program pursuant to 42 United States Code, Section 1395x(t), determines that that use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. [1997, c. 701, §4 (NEW).]
- B. "Off-label use" means the prescription and use of drugs for medically accepted indications other than those stated in the labeling approved by the federal Food and Drug Administration. [1997, c. 701, §4 (NEW).]
- C. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [1997, c. 701, §4 (NEW).]
- D. "Standard reference compendia" means:
- (1) The United States Pharmacopeia Drug Information or information published by its successor organization; or
 - (2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [1997, c. 701, §4 (NEW).]

[1997, c. 701, §4 (NEW) .]

2. Required coverage for off-label use. All health maintenance organization individual and group contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

- A. Health maintenance organization individual and group contracts that provide coverage for prescription drugs may not exclude coverage of any such drug used for the treatment of cancer for a medically accepted indication on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that use of that drug is a medically accepted indication for the treatment of cancer. [1997, c. 701, §4 (NEW).]
- B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §4 (NEW).]
- C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [1997, c. 701, §4 (NEW).]
- D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [1997, c. 701, §4 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [1997, c. 701, §4 (NEW).]

[1997, c. 701, §4 (NEW) .]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 701, §4 (NEW) .]

SECTION HISTORY

1997, c. 701, §4 (NEW).

24-A §4234-E. OFF-LABEL USE OF PRESCRIPTION DRUGS FOR HIV OR AIDS

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Off-label use" means the prescription and use of drugs for indications other than those stated in the labeling approved by the federal Food and Drug Administration. [1997, c. 701, §4 (NEW).]

B. "Peer-reviewed medical literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present data that supports the proposed off-label use as generally safe and effective. [1997, c. 701, §4 (NEW).]

C. "Standard reference compendia" means:

(1) The United States Pharmacopeia Drug Information or information published by its successor organization; or

(2) The American Hospital Formulary Service Drug Information or information published by its successor organization. [1997, c. 701, §4 (NEW).]

[1997, c. 701, §4 (NEW) .]

2. Required coverage for off-label use. All health maintenance organization individual and group contracts that provide coverage for prescription drugs must provide coverage for off-label use in accordance with the following.

A. Health maintenance organization individual and group contracts that provide coverage for prescription drugs may not exclude coverage of any such drug used for the treatment of HIV or AIDS on the grounds that the drug has not been approved by the federal Food and Drug Administration for that indication, as long as that drug is recognized for the treatment of that indication in one of the standard reference compendia or in peer-reviewed medical literature. [1997, c. 701, §4 (NEW).]

B. Coverage of a drug required by this subsection also includes medically necessary services associated with the administration of the drug. [1997, c. 701, §4 (NEW).]

C. This subsection may not be construed to require coverage for a drug when the federal Food and Drug Administration has determined its use to be contraindicated for treatment of the current indication. [1997, c. 701, §4 (NEW).]

D. A drug use that is covered pursuant to paragraph A may not be denied coverage based on a "medical necessity" requirement except for a reason that is unrelated to the legal status of the drug use. [1997, c. 701, §4 (NEW).]

E. A contract that provides coverage of a drug as required by this subsection may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the same extent that these provisions are applicable to coverage of all prescription drugs and are not inconsistent with the requirements of this subsection. [1997, c. 701, §4 (NEW).]

[1997, c. 701, §4 (NEW) .]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1999. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 701, §4 (NEW) .]

SECTION HISTORY

1997, c. 701, §4 (NEW).

24-A §4235. STANDARDIZED CLAIM FORMS

All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. A health maintenance organization may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985. All services provided by a health care practitioner in an office setting must be submitted on the standardized federal form used by noninstitutional providers and suppliers. Services in a nonoffice setting may be billed as negotiated between the health maintenance organization and health care practitioner. For purposes of this section, "office setting" means a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility. [2005, c. 97, §4 (AMD).]

SECTION HISTORY

1993, c. 477, §D12 (NEW). 1993, c. 477, §F1 (AFF). 2003, c. 218, §8 (AMD). 2003, c. 469, §D8 (AMD). 2003, c. 469, §D9 (AFF). 2005, c. 97, §4 (AMD).

24-A §4236. CHIROPRACTORS IN HEALTH MAINTENANCE ORGANIZATIONS

Every health maintenance organization shall include in every plan for health care services chiropractic services delivered by qualified chiropractic providers in accordance with this section. [1993, c. 669, §6 (NEW) .]

1. Qualifications of chiropractic providers. The health maintenance organization shall determine the qualifications of chiropractic providers using reasonable standards that are similar to and consistent with the standards applied to other providers.

[1993, c. 669, §6 (NEW) .]

2. Benefits. The health maintenance organization shall provide benefits covering care by chiropractic providers at least equal to and consistent with the benefits paid to other health care providers treating similar neuro-musculoskeletal conditions.

[1993, c. 669, §6 (NEW) .]

3. Self-referrals for chiropractic care. A health maintenance organization must provide benefits to an enrollee who utilizes the services of a chiropractic provider by self-referral under the following conditions.

A. An enrollee may utilize the services of a participating chiropractic provider within the enrollee's health maintenance organization for 3 weeks or a maximum of 12 visits, whichever occurs first, of acute care treatment without the prior approval of a primary care provider of the health maintenance organization. For purposes of this subsection, "acute care treatment" means treatment for accidental bodily injury or sudden, severe pain that affects the ability of the enrollee to engage in the normal activities, duties or responsibilities of daily living. [1995, c. 350, §1 (NEW) .]

B. Within 3 working days of the first consultation, the participating chiropractic provider shall send to the primary care provider a report containing the enrollee's complaint, related history, examination, initial diagnosis and treatment plan. If the chiropractic provider fails to send a report to the primary care provider within 3 working days, the health maintenance organization is not obligated to provide benefits for chiropractic care and the enrollee is not liable to the chiropractic provider for any unpaid fees. [1995, c. 350, §1 (NEW) .]

C. If the enrollee and the participating chiropractic provider determine that the condition of the enrollee has not improved after 3 weeks of treatment or a maximum of 12 visits the participating chiropractic provider shall discontinue treatment and refer the enrollee to the primary care provider. [1995, c. 350, §1 (NEW) .]

D. If the chiropractic provider recommends treatment beyond 3 weeks or a maximum of 12 visits, the participating chiropractic provider shall send to the primary care provider a report containing information on the enrollee's progress and outlining a treatment plan for extended chiropractic care of up to 5 more weeks or a maximum of 12 more visits, whichever occurs first. [1995, c. 350, §1 (NEW) .]

E. Without the approval of the primary care provider, an enrollee may not receive benefits for more than 36 visits to a participating chiropractic provider in a 12-month period. After a maximum of 36 visits, an enrollee's continuing chiropractic treatment must be authorized by the primary care provider. [1995, c. 350, §1 (NEW) .]

In the provision of chiropractic services under this subsection, a participating chiropractic provider is liable for a professional diagnosis of a mental or physical condition that has resulted or may result in the chiropractic provider performing duties in a manner that endangers the health or safety of an enrollee.

The provisions of this subsection apply to all health maintenance organization contracts, except a contract between a health maintenance organization and the State Employee Health Insurance Program.

This subsection takes effect January 1, 1996.

[1997, c. 99, §1 (AMD) .]

SECTION HISTORY

1993, c. 669, §6 (NEW). 1995, c. 350, §1 (AMD). 1997, c. 99, §1 (AMD).

24-A §4237. COVERAGE FOR BREAST CANCER TREATMENT

1. Inpatient care. All individual and group coverage subject to this chapter that provides coverage for medical and surgical benefits must ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time determined by the attending physician, in consultation with the patient, to be medically appropriate following a mastectomy, a lumpectomy or a lymph node dissection for the treatment of breast cancer.

Nothing in this subsection may be construed to require the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is appropriate.

In implementing the requirements of this subsection, an individual or group coverage contract may not modify the terms and conditions of coverage based on the determination by any enrollee to request less than the minimum coverage required under this subsection.

All individual and group coverage subject to this subsection must provide written notice to each enrollee under the contract regarding the coverage required by this subsection. The notice must be prominently positioned in any literature or correspondence made available or distributed by the plan and must be transmitted in the next mailing made by the plan to the enrollee or as part of any yearly information packet sent to the enrollee, whichever is earlier.

[1997, c. 408, §7 (NEW); 1997, c. 408, §8 (AFF) .]

2. Reconstruction. All individual and group coverage subject to this chapter that provides coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.

[1997, c. 408, §7 (NEW); 1997, c. 408, §8 (AFF) .]

3. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §24 (NEW) .]

SECTION HISTORY

1995, c. 295, §5 (NEW). 1995, c. 369, §4 (NEW). 1995, c. 418, §C4 (NEW). RR 1995, c. 1, §19 (COR). RR 1995, c. 1, §21 (COR). 1997, c. 408, §8 (AFF). 1997, c. 408, §7 (RPR). 2003, c. 517, §B24 (AMD).

24-A §4237-A. SCREENING MAMMOGRAMS

1. Definition. For purposes of this section, "screening mammogram" means a radiologic procedure that is provided to an asymptomatic woman for the purpose of early detection of breast cancer and that consists of 2 radiographic views per breast. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive.

[2007, c. 153, §3 (AMD); 2007, c. 153, §5 (AFF) .]

2. Required coverage. All individual and group coverage subject to this chapter must provide coverage for screening mammograms performed by providers that meet the standards established by the Department of Health and Human Services rules relating to radiation protection. The policies must reimburse for screening mammograms performed at least once a year for women 40 years of age and over.

[1997, c. 408, §7 (NEW); 1997, c. 408, §8 (AFF); 2003, c. 689, Pt. B, §6 (REV) .]

3. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §25 (NEW) .]

SECTION HISTORY

1997, c. 408, §7 (NEW). 1997, c. 408, §8 (AFF). 2003, c. 517, §B25 (AMD). 2003, c. 689, §B6 (REV). 2007, c. 153, §3 (AMD). 2007, c. 153, §5 (AFF).

24-A §4238. MEDICAL FOOD COVERAGE FOR INBORN ERROR OF METABOLISM

1. Inborn error of metabolism; special modified low-protein food product. As used in this section, "inborn error of metabolism" means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. As used in this section, "special modified low-protein food product" means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

[1995, c. 369, §4 (NEW) .]

2. Required coverage. All health maintenance organization individual and group contracts must provide coverage for metabolic formula and special modified low-protein food products that have been prescribed by a licensed physician for a person with an inborn error of metabolism. The contracts must reimburse:

A. For metabolic formula; and [1995, c. 369, §4 (NEW) .]

B. Up to \$3,000 per year for special modified low-protein food products. [1995, c. 369, §4 (NEW) .]

[1995, c. 369, §4 (NEW) .]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 1996. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1995, c. 369, §4 (NEW) .]

SECTION HISTORY

1995, c. 369, §4 (NEW). RR 1995, c. 1, §19 (RNU).

24-A §4239. MEDICAL CHILD SUPPORT

A health maintenance organization must comply with 42 United States Code, Section 1396g-1. [1995, c. 418, Pt. C, §4 (NEW).]

SECTION HISTORY

1995, c. 418, §C4 (NEW). RR 1995, c. 1, §21 (RNU).

24-A §4240. COVERAGE FOR DIABETES SUPPLIES

All health maintenance organization individual and group health contracts and certificates must provide coverage for the medically appropriate and necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if: [2003, c. 517, Pt. A, §10 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

1. Certification of medical necessity. The enrollee's treating physician or a physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary; and

[1995, c. 592, §4 (NEW) .]

2. Provision of medical services. The diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

[1995, c. 592, §4 (NEW) .]

The requirements of this section apply to all group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. [2003, c. 517, Pt. A, §10 (NEW); 2003, c. 517, Pt. A, §13 (AFF).]

§4240. Coverage for Pap tests

(As enacted by PL 1995, c. 617, §5 is REALLOCATED TO TITLE 24-A, SECTION 4242)

SECTION HISTORY

1995, c. 592, §4 (NEW). 1995, c. 617, §5 (NEW). 1995, c. 617, §6 (AFF). RR 1995, c. 2, §53 (RAL). 2003, c. 517, §A10 (AMD). 2003, c. 517, §A13 (AFF).

24-A §4241. GYNECOLOGICAL AND OBSTETRICAL SERVICES

1. Coverage in managed care plans. With respect to managed care plans that require enrollees to select primary care physicians, a health maintenance organization that issues group policies, contracts and certificates must meet the following requirements.

A. The health maintenance organization must permit a physician who specializes in obstetrics and gynecology to serve as a primary care physician if the physician qualifies under the organization's credentialing policy. [1995, c. 617, §5 (NEW); 1995, c. 617, §6 (AFF).]

B. All group plan contracts must provide coverage for an annual gynecological examination, including routine pelvic and clinical breast examinations, performed by a physician, certified nurse practitioner or certified nurse midwife participating in the plan, without requiring the prior approval of the primary care physician. [1995, c. 617, §5 (NEW); 1995, c. 617, §6 (AFF).]

C. If the examination specified in paragraph B reveals a gynecological condition for which another visit to the physician participating in the plan is medically required and appropriate, or for any gynecological care beyond the annual examination, the carrier may require the patient or the examining physician, certified nurse practitioner or certified nurse midwife to secure from the patient's primary care physician a referral to the participating physician, certified nurse practitioner or certified nurse midwife from whom such care may be obtained. [1995, c. 617, §5 (NEW); 1995, c. 617, §6 (AFF).]

[2003, c. 517, Pt. A, §11 (AMD); 2003, c. 517, Pt. A, §13 (AFF) .]

2. Application. This section applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. A, §11 (AMD); 2003, c. 517, Pt. A, §13 (AFF) .]

This section does not prohibit a carrier from requiring a physician, certified nurse practitioner or certified nurse midwife participating in the plan to inform a woman's primary care physician prior to each treatment pursuant to this section. [1995, c. 617, §5 (NEW); 1995, c. 617, §6 (AFF).]

SECTION HISTORY

1995, c. 617, §5 (NEW). 1995, c. 617, §6 (AFF). 2003, c. 517, §A11 (AMD). 2003, c. 517, §A13 (AFF).

24-A §4242. COVERAGE FOR PAP TESTS

(REALLOCATED FROM TITLE 24-A, SECTION 4240)

All health maintenance organization plan contracts and certificates must provide coverage for screening Pap tests recommended by a physician. [2003, c. 517, Pt. A, §12 (AMD); 2003, c. 517, Pt. A, §13 (AFF).]

SECTION HISTORY

RR 1995, c. 2, §53 (RAL). 2003, c. 517, §A12 (AMD). 2003, c. 517, §A13 (AFF).

24-A §4243. LIMITS ON PRIORITY LIENS; SUBROGATION

An individual or group contract subject to this chapter may not provide for subrogation or priority over the enrollee of payment for any hospital, nursing, medical or surgical services or of any expenses paid or reimbursed under the coverage, in the event the enrollee is entitled to receive payment or reimbursement from any other person as a result of legal action or claim, except as provided in this section. [1997, c. 369, §3 (NEW).]

The coverage may contain a provision that allows the payments, if that provision is approved by the superintendent and if that provision required the prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. A "just and equitable basis" means that any factors that diminish the potential value of the enrollee's claim may likewise reduce the share in the claim for those claiming payment for services or reimbursement. Such factors include, but are not limited to: [1997, c. 369, §3 (NEW).]

1. Legal defenses. Questions of liability and comparative negligence or other legal defenses;

[1997, c. 369, §3 (NEW) .]

2. Exigencies of trial. Exigencies of trial that reduce a settlement or award in order to resolve the claim; and

[1997, c. 369, §3 (NEW) .]

3. Limits of coverage. Limits on the amount of applicable insurance coverage that reduce the claim to an amount recoverable by the insured.

[1997, c. 369, §3 (NEW) .]

In the event of a dispute as to the application of any such provision or the amount available for payment to those claiming payment for services or reimbursement, that dispute must be determined, if the action is pending, before the court in which it is pending; or if no action is pending, by filing an action in any court for determination of the dispute. [1997, c. 369, §3 (NEW).]

§4243. Coverage for prostate cancer screening

(As enacted by PL 1997, c. 754, §4 is REALLOCATED TO TITLE 24-A, SECTION 4244)

SECTION HISTORY

1997, c. 369, §3 (NEW). 1997, c. 754, §4 (NEW). RR 1997, c. 2, §53 (RAL).

24-A §4244. COVERAGE FOR PROSTATE CANCER SCREENING

(REALLOCATED FROM TITLE 24-A, SECTION 4243)

1. Definition. As used in this section, "services for the early detection of prostate cancer" means the following procedures provided to a man for the purpose of early detection of prostate cancer:

A. A digital rectal examination; and [1997, c. 2, §53 (RAL) .]

B. A prostate-specific antigen test. [1997, c. 2, §53 (RAL) .]

[1997, c. 2, §53 (RAL) .]

2. Required coverage for prostate cancer screening. All health maintenance organization individual and group contracts must provide coverage for services for the early detection of prostate cancer. The contracts must reimburse for services for the early detection of prostate cancer, if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72.

[1997, c. 2, §53 (RAL) .]

3. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after September 1, 1998. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[1997, c. 2, §53 (RAL) .]

SECTION HISTORY

RR 1997, c. 2, §53 (RAL).

24-A §4245. NCQA ACCREDITATION SURVEY REPORT

1. Access and confidentiality. The superintendent or the Commissioner of Health and Human Services may require a health maintenance organization to submit its NCQA accreditation survey report. An NCQA accreditation survey report obtained by or submitted to the superintendent or the Commissioner of Health and Human Services is confidential, is not subject to subpoena and may not be made public by the superintendent or the Commissioner of Health and Human Services except as otherwise provided in this section.

[1999, c. 256, Pt. Q, §2 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

2. Use in examination. In conducting an examination of a health maintenance organization pursuant to section 4215, the superintendent or the Commissioner of Health and Human Services has the discretion to adopt relevant findings in the NCQA accreditation survey report in whole or in part as the examiner's conclusions, if the examiner determines that the NCQA survey, by itself or in combination with the examiner's own findings, sufficiently demonstrates that the health maintenance organization has satisfied the pertinent requirements of this chapter. If the NCQA accreditation survey report indicates that the health maintenance organization may not be in compliance with one or more requirements of this chapter, the examiner may investigate and make independent findings.

[1999, c. 256, Pt. Q, §2 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

3. Examination report. The information from the NCQA accreditation survey report that sufficiently demonstrates that the health maintenance organization has satisfied the pertinent requirements of this section as adopted by the superintendent or the Commissioner of Health and Human Services pursuant to subsection 2 may be incorporated into an examination report, which is a public record except for any information relating to an individual applicant or enrollee.

[1999, c. 256, Pt. Q, §2 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

4. Use of information for regulatory purposes. The confidentiality of the NCQA accreditation survey report does not prohibit its use by the superintendent or the Commissioner of Health and Human Services for regulatory or law enforcement purposes subject to the restrictions of section 216, subsection 5 and section 226, subsection 7.

§4245. Coverage for contraceptives

(As enacted by PL 1999, c. 341, §4 and affected by §5 is REALLOCATED TO TITLE 24-A, SECTION 4247)

§4245. Coverage for services of certified nurse practitioners; certified nurse midwives

(As enacted by PL 1999, c. 396, §4 and affected by §7 is REALLOCATED TO TITLE 24-A, SECTION 4248)

[1999, c. 256, Pt. Q, §2 (NEW); 2003, c. 689, Pt. B, §7 (REV) .]

SECTION HISTORY

1999, c. 256, §Q2 (NEW). 1999, c. 341, §4 (NEW). 1999, c. 396, §4 (NEW). 1999, c. 341, §5 (AFF). 1999, c. 396, §7 (AFF). RR 1999, c. 1, §§37,38 (RAL). 2003, c. 689, §B7 (REV).

24-A §4246. COVERAGE FOR SERVICES PROVIDED BY REGISTERED NURSE FIRST ASSISTANTS

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Perioperative nursing" means a practice of nursing in which the nurse provides preoperative, intraoperative and postoperative nursing care to surgical patients. [1999, c. 412, §4 (NEW) .]

B. "Recognized program" means a program that addresses all content of the core curriculum for registered nurse first assistants as established by the Association of Operating Room Nurses or its successor organization. [1999, c. 412, §4 (NEW).]

C. "Registered nurse first assistant," or "RNFA," means a person who:

- (1) Is licensed as a registered nurse under Title 32, chapter 31;
- (2) Is experienced in perioperative nursing; and
- (3) Has successfully completed a recognized program. [1999, c. 412, §4 (NEW).]

[1999, c. 412, §4 (NEW) .]

2. Institutional powers. Each health care institution, as defined in Title 22, chapter 405, may establish specific procedures for the appointment and reappointment of registered nurse first assistants and for granting, renewing and revising their clinical privileges.

[1999, c. 412, §4 (NEW) .]

3. Required coverage for services. Notwithstanding any other provisions of this chapter, a health maintenance organization that issues individual and group health care contracts that provide coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications. The provisions of this subsection apply only if reimbursement for an assisting physician would be covered and a registered nurse first assistant who performed those services is used as a substitute.

[1999, c. 412, §4 (NEW) .]

4. Limits; coinsurance; deductibles. Any contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1999, c. 412, §4 (NEW) .]

5. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 617, Pt. B, §26 (NEW) .]

SECTION HISTORY

1999, c. 412, §4 (NEW). 2003, c. 517, §B26 (AMD).

24-A §4247. COVERAGE FOR CONTRACEPTIVES

(REALLOCATED FROM TITLE 24-A, SECTION 4245)

1. Coverage requirements. All health maintenance organization individual and group health contracts that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives approved by the federal Food and Drug Administration or for outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services. For purposes of this section, the term "outpatient contraceptive services"

means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy. This section may not be construed to apply to prescription drugs or devices that are designed to terminate a pregnancy.

[1999, c. 1, §37 (RAL) .]

2. Exclusion for religious employer. A religious employer may request and a health maintenance organization shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. A religious employer that obtains an exclusion under this subsection shall provide prospective insureds and those individuals insured under its policy written notice of the exclusion. This section may not be construed as authorizing a health maintenance organization to exclude coverage for prescription drugs prescribed for reasons other than contraceptive purposes or for prescription contraception that is necessary to preserve the life or health of a covered person. For the purposes of this section, "religious employer" means an employer that is a church, convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121 (w) (3) (A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c) (3).

[1999, c. 1, §37 (RAL) .]

3. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §27 (NEW) .]

SECTION HISTORY

RR 1999, c. 1, §37 (RAL). 2003, c. 517, §B27 (AMD).

24-A §4248. COVERAGE FOR SERVICES OF CERTIFIED NURSE PRACTITIONERS; CERTIFIED NURSE MIDWIVES

(REALLOCATED FROM TITLE 24-A, SECTION 4245)

1. Required coverage for services upon referral of primary care provider. A health maintenance organization that issues individual and group health care contracts shall provide coverage under those contracts for services performed by a participating certified nurse practitioner or participating certified nurse midwife to a patient who is referred to the participating certified nurse practitioner or participating certified nurse midwife by a primary care provider when those services are within the lawful scope of practice of the participating certified nurse practitioner or participating certified nurse midwife.

[1999, c. 1, §38 (RAL) .]

2. Required coverage for self-referred services. With respect to individual and group health care contracts that do not require the selection of a primary care provider, a health maintenance organization shall provide coverage under those contracts for services performed by a participating certified nurse practitioner or participating certified nurse midwife when those services are covered services and when they are within the lawful scope of practice of the participating certified nurse practitioner or participating certified nurse midwife.

[1999, c. 1, §38 (RAL) .]

3. Limits; coinsurance; deductibles. Any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[1999, c. 1, §38 (RAL) .]

4. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §28 (NEW) .]

SECTION HISTORY

RR 1999, c. 1, §38 (RAL). 2003, c. 517, §B28 (AMD).

24-A §4249. MANDATED OFFER OF DOMESTIC PARTNER BENEFITS

1. Definition. As used in this section, unless the context otherwise indicates, "domestic partner" means the partner of an enrollee or member who:

A. Is a mentally competent adult as is the enrollee or member; [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

B. Has been legally domiciled with the enrollee or member for at least 12 months; [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

C. Is not legally married to or legally separated from another individual; [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

D. Is the sole partner of the enrollee or member and expects to remain so; and [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

E. Is jointly responsible with the enrollee or member for each other's common welfare as evidenced by joint living arrangements, joint financial arrangements or joint ownership of real or personal property. [2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF).]

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

2. Mandated offer of domestic partner benefits. All individual or group policies or contracts issued by any health maintenance organization operating pursuant to this chapter must make available to an individual or group policyholder the option for additional benefits for the domestic partner of an enrollee or member, at appropriate rates and under the same terms and conditions as those benefits or options for benefits are provided to spouses of married enrollees or members covered under a health maintenance organization individual or group contract.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

3. Financial dependency. Financial dependency of a domestic partner on the enrollee or member may not be required as a condition for eligibility for coverage.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

4. Evidence of domestic partnership. As a condition of eligibility for coverage, a health maintenance organization or group policyholder may require an enrollee or member and the enrollee's or member's domestic partner to sign an affidavit attesting that the enrollee or member and enrollee's or member's domestic

partner meet the definition in subsection 1 and to show documentation of joint ownership or occupancy of real property, such as a joint deed, joint mortgage or a joint lease, or the existence of a joint credit card, joint bank account or powers of attorney in which each domestic partner is authorized to act for the other.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

5. Preexisting conditions. A domestic partner is subject to the same provisions on coverage of preexisting conditions as any spouse or dependent of an enrollee or member.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

6. Termination of domestic partner benefits. A health maintenance organization may terminate coverage in accordance with other applicable provisions of this Title for the domestic partner of an enrollee or member upon notification by the enrollee or member that the domestic partner relationship has terminated. An enrollee or member may not enroll another individual as a domestic partner under an individual or group contract until 12 months after the termination of coverage for a prior domestic partner.

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

7. Construction. This section does not prohibit a health maintenance organization from negotiating a policy providing domestic partner benefits to a policyholder that does not comply with the requirements of this section.

§4249. Coverage for hospice care services

(As enacted by PL 2001, c. 358, Pt. LL, §4 and affected by §5 is REALLOCATED TO TITLE 24-A, SECTION 4250)

§4249. Coverage for general anesthesia for dentistry

(As enacted by PL 2001, c. 423, §4 and affected by §5 is REALLOCATED TO TITLE 24-A, SECTION 4251)

[2001, c. 347, §4 (NEW); 2001, c. 347, §5 (AFF) .]

SECTION HISTORY

2001, c. 347, §4 (NEW). 2001, c. 358, §LL4 (NEW). 2001, c. 423, §4 (NEW). 2001, c. 347, §5 (AFF). 2001, c. 358, §LL5 (AFF). 2001, c. 423, §5 (AFF). RR 2001, c. 1, §§36,37 (RAL).

24-A §4250. COVERAGE FOR HOSPICE CARE SERVICES

(REALLOCATED FROM TITLE 24-A, SECTION 4249)

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to a person who is terminally ill and that person's family. "Hospice care services" includes, but is not limited to, physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services. [2001, c. 1, §36 (RAL).]

B. "Person who is terminally ill" means a person that has a medical prognosis that the person's life expectancy is 12 months or less if the illness runs its normal course. [2001, c. 1, §36 (RAL).]

[2001, c. 1, §36 (RAL) .]

2. Coverage for hospice care services. All health maintenance organization individual and group health contracts must provide coverage for hospice care services to a person who is terminally ill. Hospice care services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of hospice care services. Coverage for hospice care services must be provided whether the services are provided in a home setting or an inpatient setting.

[2001, c. 1, §36 (RAL) .]

3. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §29 (NEW) .]

SECTION HISTORY

RR 2001, c. 1, §36 (RAL). 2003, c. 517, §B29 (AMD).

24-A §4251. COVERAGE FOR GENERAL ANESTHESIA FOR DENTISTRY (REALLOCATED FROM TITLE 24-A, SECTION 4249)

2. General anesthesia and associated facility charges. All individual and group health maintenance organization contracts must provide coverage for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the clinical status or underlying medical condition of an enrollee requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital. The insurer may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

[2001, c. 1, §37 (RAL) .]

3. Limitations on coverage. This section applies only to general anesthesia and associated facility charges for only the following enrollees if the enrollees meet the criteria in subsection 2:

- A. Enrollees, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; [2001, c. 1, §37 (RAL) .]
- B. Enrollees demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; [2001, c. 1, §37 (RAL) .]
- C. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and [2001, c. 1, §37 (RAL) .]
- D. Enrollees who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised. [2001, c. 1, §37 (RAL) .]

[2001, c. 1, §37 (RAL) .]

4. Dental procedures and dentist's fee not covered. This section does not require a health maintenance organization to cover any charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section is subject to all other terms and conditions of the individual or group contract that apply generally to other benefits.

[2001, c. 1, §37 (RAL) .]

5. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is also eligible for coverage for general anesthesia and associated facility charges under a dental insurance policy or contract, the nonprofit health care service organization or insurer providing dental insurance is the primary payer responsible for those charges and the health maintenance organization providing health coverage is the secondary payer.

[2001, c. 1, §37 (RAL) .]

6. Application. The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2003, c. 517, Pt. B, §30 (NEW) .]

SECTION HISTORY

RR 2001, c. 1, §37 (RAL). 2003, c. 517, §B30 (AMD).

24-A §4252. OFFER OF COVERAGE FOR BREAST REDUCTION SURGERY AND SYMPTOMATIC VARICOSE VEIN SURGERY

All health maintenance organization individual and group health insurance policies, contracts and certificates must make available coverage for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary health care as defined in section 4301-A, subsection 10-A. [2005, c. 128, §4 (NEW); 2005, c. 128, §5 (AFF) .]

SECTION HISTORY

2005, c. 128, §4 (NEW). 2005, c. 128, §5 (AFF).

24-A §4253. ENROLLMENT FOR INDIVIDUALS OR FAMILIES ESTABLISHING ELIGIBILITY FOR MAINECARE

When an individual or family is eligible for MaineCare and is also eligible for health maintenance organization coverage provided by an employer through a health maintenance organization, the health maintenance organization must permit the individual or family to enroll in the health maintenance organization coverage without regard to any enrollment season restrictions. [2007, c. 448, §12 (NEW) .]

§4253. Coverage for hearing aids

(As enacted by PL 2007, c. 452, §4 is REALLOCATED TO TITLE 24-A, SECTION 4255)

SECTION HISTORY

2007, c. 448, §12 (NEW). 2007, c. 695, Pt. A, §30 (RAL).

24-A §4254. COVERAGE FOR COLORECTAL CANCER SCREENING

1. Colorectal cancer screening. For the purposes of this section, "colorectal cancer screening" means a colorectal cancer examination and laboratory test recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society.

[2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF) .]

2. Required coverage. All health maintenance organization individual and group health insurance policies, contracts and certificates must provide coverage for colorectal cancer screening for asymptomatic individuals who are:

A. Fifty years of age or older; or [2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF) .]

B. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. [2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF) .]

[2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF) .]

3. Billing. If a colonoscopy is recommended by a health care provider as the colorectal cancer screening test in accordance with this section and a lesion is discovered and removed during that colonoscopy, the health care provider must bill the insurance company for a screening colonoscopy as the primary procedure.

§4254. Coverage for medically necessary infant formula

(As enacted by PL 2007, c. 595, §4 is REALLOCATED TO TITLE 24-A, SECTION 4256)

[2007, c. 516, §4 (NEW); 2007, c. 516, §5 (AFF) .]

SECTION HISTORY

2007, c. 516, §4 (NEW). 2007, c. 516, §5 (AFF). 2007, c. 695, Pt. C, §16 (RAL).

24-A §4255. COVERAGE FOR HEARING AIDS

(REALLOCATED FROM TITLE 24-A, SECTION 4253)

1. Hearing aid; definition. For purposes of this section, "hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

[2007, c. 695, Pt. A, §30 (RAL) .]

2. Required coverage. In accordance with the application of coverage set forth in subsection 3, all health maintenance organization individual and group health insurance contracts must provide coverage for the purchase of a hearing aid for each hearing-impaired ear for an individual covered under the policy, contract or certificate who is 18 years of age or under in accordance with the following requirements.

A. The hearing loss must be documented by a physician or audiologist licensed pursuant to Title 32, chapter 77. [2007, c. 695, Pt. A, §30 (RAL) .]

B. The hearing aid must be purchased from an audiologist licensed pursuant to Title 32, chapter 77 or a hearing aid dealer licensed pursuant to Title 32, chapter 23-A. [2007, c. 695, Pt. A, §30 (RAL) .]

C. The policy, contract or certificate may limit coverage to \$1,400 per hearing aid for each hearing-impaired ear every 36 months. [2007, c. 695, Pt. A, §30 (RAL).]

[2007, c. 695, Pt. A, §30 (RAL) .]

3. Application of coverage. The requirements of subsection 2 apply to an individual:

A. From birth to 5 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2008; [2007, c. 695, Pt. A, §30 (RAL).]

B. From 6 to 13 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2009; and [2007, c. 695, Pt. A, §30 (RAL).]

C. From 14 to 18 years of age, who is covered under a contract that is issued or renewed on or after January 1, 2010. [2007, c. 695, Pt. A, §30 (RAL).]

[2007, c. 695, Pt. A, §30 (RAL) .]

4. Limits; coinsurance; deductibles. Except as otherwise provided in this section, any contract that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2007, c. 695, Pt. A, §30 (RAL) .]

SECTION HISTORY

2007, c. 695, Pt. A, §30 (RAL).

24-A §4256. COVERAGE FOR MEDICALLY NECESSARY INFANT FORMULA (*REALLOCATED FROM TITLE 24-A, SECTION 4254*)

All individual and group health maintenance organization policies, contracts and certificates must provide coverage for amino acid-based elemental infant formula for children 2 years of age and under in accordance with this section. [2007, c. 695, Pt. C, §16 (RAL).]

1. Determination of medical necessity. Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is medically necessary health care as defined in section 4301-A, subsection 10-A, that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas have been tried and have failed or are contraindicated. A licensed physician may be required to confirm and document ongoing medical necessity at least annually.

[2007, c. 695, Pt. C, §16 (RAL) .]

2. Method of delivery. Coverage for amino acid-based elemental infant formula must be provided without regard to the method of delivery of the formula.

[2007, c. 695, Pt. C, §16 (RAL) .]

3. Required diagnosis. Coverage for amino acid-based elemental infant formula must be provided when a licensed physician has diagnosed and through medical evaluation has documented one of the following conditions:

A. Symptomatic allergic colitis or proctitis; [2007, c. 695, Pt. C, §16 (RAL).]

B. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; [2007, c. 695, Pt. C, §16 (RAL).]

C. A history of anaphylaxis; [2007, c. 695, Pt. C, §16 (RAL).]

D. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies; [2007, c. 695, Pt. C, §16 (RAL).]

E. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; [2007, c. 695, Pt. C, §16 (RAL).]

F. Cystic fibrosis; or [2007, c. 695, Pt. C, §16 (RAL).]

G. Malabsorption of cow milk-based or soy milk-based infant formula. [2007, c. 695, Pt. C, §16 (RAL).]

[2007, c. 695, Pt. C, §16 (RAL) .]

4. Health savings accounts. Coverage for amino acid-based elemental infant formula under a health insurance policy, contract or certificate issued in connection with a health savings account as authorized under Title XII of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductible and out-of-pocket limits that apply to overall benefits under the policy, contract or certificate.

[2007, c. 695, Pt. C, §16 (RAL) .]

SECTION HISTORY

2007, c. 695, Pt. C, §16 (RAL).

24-A §4257. COVERAGE FOR SERVICES PROVIDED BY INDEPENDENT PRACTICE DENTAL HYGIENIST

1. Services provided by independent practice dental hygienist. All individual and group health maintenance organization contracts that include coverage for dental services shall provide coverage for dental services performed by an independent practice dental hygienist licensed under Title 32, chapter 16, subchapter 3-B when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist.

[2009, c. 307, §4 (NEW); 2009, c. 307, §6 (AFF) .]

2. Limits; coinsurance; deductibles. A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

[2009, c. 307, §4 (NEW); 2009, c. 307, §6 (AFF) .]

3. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health maintenance organization policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the health maintenance organization providing health coverage is the secondary payer.

[2009, c. 307, §4 (NEW); 2009, c. 307, §6 (AFF) .]

4. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

[2009, c. 307, §4 (NEW); 2009, c. 307, §6 (AFF) .]

SECTION HISTORY

2009, c. 307, §4 (NEW). 2009, c. 307, §6 (AFF).

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