

## Virginia's Proposed Revisions to the NAIC's Health Maintenance Organization Model Act (#430)

### **Section 3. Definitions**

- A. "Adverse determination" means a determination by a health maintenance organization or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health maintenance organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.
- B. "Basic health care services" includes the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.
- C. "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.
- D. "Coinsurance" means the percentage amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

**Drafting Note:** States that do not allow HMOs to impose a coinsurance requirement should not adopt this definition nor include the term when it is referenced throughout the model.

- E. "Commissioner" means the insurance commissioner of this state.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of health maintenance organizations lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- F. "Copayment" means a specified dollar amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.
- G. "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- H. "Covered person" means any person eligible to receive covered benefits under the

terms of a health benefit plan.

- I. “Deductible” means the amount a covered person is responsible to pay out-of-pocket before the health maintenance organization begins to pay the covered expenses associated with treatment.
- J. “Enrollee” means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.
- K. “Evidence of coverage” means a statement that sets out the coverage and other rights to which the covered person is entitled under the health benefit plan and that may be issued by the health maintenance organization or by the group contract holder to an enrollee electronically or, upon request, in writing.
- L. “Extension of benefits” means the continuation of coverage under a particular benefit provided under a contract following termination with respect to a covered person who is totally disabled on the date of termination.
- M. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- N. “Grievance” means a written complaint submitted by or on behalf of a covered person regarding:
  - (1) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
  - (2) Claims payment, handling or reimbursement for health care services; or
  - (3) Matters pertaining to the contractual relationship between a covered person and a health maintenance organization.
- O. “Group contract” means a contract for health care services, which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.
- P. “Group contract holder” means a person, other than an individual, to which a group contract has been issued.

- Q. “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- R. “Health care professional” means a physician or other health care practitioner license, accredited or certified to perform specified health services consistent with state law.
- S. “Health care provider” or “provider” means a health care professional or facility.
- T. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- U. “Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, managed care organization, health maintenance organization, a nonprofit hospital or medical service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

**Drafting Note:** States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

**Drafting Note:** The term “hospital or medical service corporation,” as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as “Blue Cross Blue Shield-type” plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

- V. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.
- W. “Individual contract” means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.
- X. “Insolvent” or “insolvency” shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.
- Y. “Intermediary organization” means a person, other than an individual, authorized to negotiate and execute provider contracts with health maintenance organizations on behalf of a group of health care providers or on behalf of a network, but does not include a provider or group of providers negotiating on its own behalf.
- Z. “Network” means the group of participating providers providing services to a health

maintenance organization.

- AA. “Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.
- BB. “Participating provider” means a provider that, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.
- CC. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or a combination of the foregoing.
- DD. “Policyholder” means, for individual contracts, the individual in whose name the contract is issued, and for group contracts, the group contract holder.
- EE. “Qualified actuary” means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the commissioner may require.
- FF. “Replacement coverage” means the benefits provided by a succeeding carrier.
- GG. “Risk bearing entity” means an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.

~~HH. “Uncovered expenditures” means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which a covered person may also be liable in the event of the health maintenance organization’s insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner.~~

~~**Drafting Note:** Subsection HH defines uncovered expenditures for use in Section 20. They will vary in type and amount, depending on the arrangements of the health maintenance organization. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the covered person even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.~~

- II. “Utilization review” means a set of formal techniques utilized by or on behalf of the health maintenance organization designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case

management, discharge planning or retrospective review.

#### **Section 14. — Continuation of Benefits**

~~A. — The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides 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 their discharge or expiration of benefits.~~

~~B. — In considering such a plan, the commissioner may require:~~

~~(1) — Insurance to cover the expenses to be paid for continued benefits after an insolvency;~~

~~(2) — Provisions in provider contracts that obligate the provider, after the health maintenance organization's insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;~~

~~(3) — Insolvency reserves;~~

~~(4) — Acceptable letters of credit; or~~

~~(5) Any other arrangements to assure that benefits are continued as specified above.~~

In the event of an insolvency benefits and coverages will be provided pursuant to [insert reference to state's guaranty association statute based on §8B(2) of the Life and Health Guaranty Association Model Act #520].

#### **Section 19. Hold Harmless Provision Requirements for Covered Persons**

A. Except for coinsurance, deductibles or copayments as specifically provided in the evidence of coverage, in no event, including but not limited to nonpayment by the health maintenance organization, insolvency of the health maintenance organization or breach of contract among the health maintenance organization, risk bearing entity or participating provider, shall a risk bearing entity or participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization) acting on behalf of the covered person for covered services provided. No risk bearing entity or participating

provider, nor any agent, trustee or assignee of the risk bearing entity or participating provider may maintain an action at law against a covered person to collect sums owed by the health maintenance organization.

B. All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for covered persons. Any attempted waiver or amendment in a manner materially adverse to the interests of covered persons of a hold harmless provision shall be null and void and unenforceable.

C. The requirement of Subsection B shall be met by including a provision substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the covered person for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons.”

D. (1) Any statement sent to a covered person shall clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(2) All contracts among health maintenance organizations, risk bearing entities, and participating providers shall require that all statements sent to covered persons clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.

(3) The notice requirements in this subsection shall be met by including in the statement to covered persons a provision substantially similar the following:

**NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY**

## AMOUNTS OWED BY YOUR HEALTH MAINTENANCE ORGANIZATION

- E. Any violation of the provisions of this section shall constitute an unfair trade practice pursuant to [insert reference to state insurance fraud statute] and shall subject the health care provider to monetary penalties in accordance with [insert reference to state insurance fraud statute] and notification to the [insert reference to appropriate licensing entity for type of provider].

**Drafting Note:** Pursuant to Section 3B(1) of the Life and Health Insurance Guaranty Association Model Act (Model #520) health care providers will be protected against loss due to an impairment or insolvency of an insurer (HMO).

**Drafting Note:** States that do not authorize insurance departments to take action against providers should not adopt Subsection E and should consider other options such as contacting the state attorney general's office or other appropriate state official.

**Drafting Note:** States with consumer protection acts that provide covered persons with a private right of action should consider including a reference in Subsection E.

### **~~Section 20. Uncovered Expenditures Deposit~~**

- ~~A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization's outstanding liability for uncovered expenditures for covered persons in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.~~
- ~~B. The deposit required under this section is in addition to the deposit required under Section 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.~~
- ~~C. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:~~
- ~~(a) A substitute deposit of cash or securities of equal amount and value is made;~~
  - ~~(b) The fair market value exceeds the amount of the required deposit;~~

~~or~~

~~(c) The required deposit under Subsection A is reduced or eliminated.~~

~~(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.~~

~~D. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of covered persons of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.~~

~~E. The commissioner may by regulation prescribe the time, manner and form for filing claims under Subsection D.~~

~~F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.~~

## ~~Section 21. Open Enrollment and Replacement Coverage in the Event of Insolvency~~

### ~~A. Enrollment Period~~

~~(1) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.~~

~~(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the~~



~~group covered persons of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for these groups 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 the 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 and in accordance with state law.~~

- ~~(3) The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees that are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer the nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.~~

#### ~~B. Replacement Coverage~~

- ~~(1) "Discontinuance" shall mean the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.~~
- ~~(2) A health maintenance organization providing replacement coverage hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization, shall immediately cover all covered persons who were validly covered under the previous health maintenance organization at the date of discontinuance and who would otherwise be eligible for~~

~~coverage under the succeeding health maintenance organization, regardless of any provisions of the contract relating to active employment, hospital confinement or pregnancy.~~

**Drafting Note:** Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in the group market, a succeeding carrier, including a health maintenance organization, is prohibited from including any nonconfinement rules in its plan of benefits and any actively-at-work rules provided in the succeeding carrier's plan of benefits must provide that absence from work due to any health status-related factor be treated as being actively-at-work.

- ~~(3) — Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding health maintenance organization's contract of replacement coverage that would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those covered persons validly covered under the prior carrier's contract or policy on the date of discontinuance.~~