

PART X. HEALTH MAINTENANCE ORGANIZATION

Chap. Sec.
301. HEALTH MAINTENANCE ORGANIZATIONS 301.1
303. OUT-OF-STATE HEALTH MAINTENANCE ORGANIZATION INVESTMENTS 303.1

Authority

The provisions of this Part X issued under the Health Maintenance Organization Act (40 P. S. §§ 1551—1567), unless otherwise noted.

Source

The provisions of this Part X adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807, unless otherwise noted.

CHAPTER 301. HEALTH MAINTENANCE ORGANIZATION

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Authority

The provisions of this Chapter 301 issued under the Health Maintenance Organization Act (40 P. S. §§ 1551—1567), unless otherwise noted.

Source

The provisions of this Chapter 301 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807, unless otherwise noted.

Cross References

This chapter cited in 28 Pa. Code § 9.601 (relating to applicability).

Subchapter A. GENERAL INFORMATION

Sec.
301.1. Applicability.
301.2. Definitions.

§ 301.1. Applicability.

This chapter applies to persons who propose to establish, maintain and operate an HMO within this Commonwealth, with the exception of HMO programs exempted under sections 16 and 17(b) of the act (40 P. S. §§ 1566 and 1567(b)).

Source

The provisions of this § 301.1 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

§ 301.2. Definitions.

(a) No contract or evidence of coverage delivered or issued for delivery to a person by an HMO established or operating in this Commonwealth may contain definitions respecting the matters in subsections (b) and (c) unless the definitions are consistent with this section.

(b) Definitions other than those in this section may be used as appropriate if they do not contradict the definitions in this subsection. Definitions used in the contracts or evidence of coverage shall be in alphabetical order.

(c) The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act—The Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

Affiliated provider or *participating provider*—A provider that has entered into a contractual agreement either directly or indirectly with an HMO to provide health care services to members.

Certificate of authority—The document issued jointly by the Secretary and the Commissioner permitting a corporation to establish, maintain and operate a health maintenance organization.

Commissioner—The Insurance Commissioner of the Commonwealth.

Contractholder—An entity consisting of employes or members which has purchased a group contract from an HMO for the provision of specific health care services to its eligible employes or members.

Department—The Insurance Department of the Commonwealth.

Evidence of coverage—A certificate, agreement or contract issued to a subscriber setting out the coverage to which the member is entitled.

Federally qualified health maintenance organization—An entity which has been found by the Secretary of the United States Department of Health and Human Services to meet the requirements of section 1301 of the Public Health Service Act (42 U.S.C.A. § 300e).

Group contract—A contract for health care services which by its terms limits eligibility to members of a specified group.

HMO—health maintenance organization—An organized system which combines the delivery and financing of health care and which provides basic health services to voluntarily enrolled members for a fixed prepaid fee.

Impaired organization—An organization which is deemed by the Commissioner, under sections 5.1(b)(2) and 10 (40 P. S. §§ 1555.1(b)(2) and 1560), to be no longer able to operate in a financially sound manner, but which is not insolvent.

Individual contract or nongroup contract—A contract for health care services issued to and covering an individual or family member.

Insolvent—The point at which an HMO's liabilities exceed its assets, as defined in section 403 of The Insurance Company Law of 1921 (40 P. S. § 503).

Medical necessity or medically necessary—Appropriate and necessary services as determined by the HMO which are rendered to a member for a condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness or injury and which are not provided only as a convenience.

Member or enrollee—An individual who is contractually entitled to receive basic health services from an HMO.

Net worth—The excess of total admitted assets over total liabilities, but not including fully subordinated debt.

Primary care physician—A physician who supervises, coordinates and provides initial and basic care to members; initiates their referral for specialist care and maintains continuity of patient care.

Provider—A physician, hospital or other person licensed and practicing within the scope of the license or otherwise authorized in this Commonwealth to furnish health care services.

Secretary—The Secretary of Health of the Commonwealth.

Service area—The geographical area as approved by the Commissioner within which the HMO provides or arranges for health services for members.

Subordinated debt—The debt which is subordinated to all other obligations of the HMO and which meets the requirements of this section.

Subscriber—A member whose employment or other status, except for family dependency, is the basis for eligibility for enrollment in the HMO.

Authority

The provisions of this § 301.2 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

Source

The provisions of this § 301.2 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807; amended September 8, 1989, effective September 9, 1989, 19 Pa.B. 3820; amended March 13, 1992, effective March 14, 1992, 22 Pa.B. 1178. Immediately preceding text appears at serial pages (163550) and (143037).

Subchapter B. DEVELOPMENT OF A HEALTH MAINTENANCE ORGANIZATION

Sec.
301.21. Preapplication development activities.

§ 301.21. Preapplication development activities.

Corporations in the process of developing an HMO are urged, but not required, to periodically inform the Department of their developmental activities and to make use of Department technical advice and assistance.

Source

The provisions of this § 301.21 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

Subchapter C. APPLICATION FOR CERTIFICATE OF AUTHORITY

Sec.
301.41. Prohibition against uncertified HMOs.
301.42. Content of application for certificate of authority.
301.43. Review by Department.

§ 301.41. Prohibition against uncertified HMOs.

No corporation may solicit enrollment of members, enroll members or deliver prepaid basic health care services by, through, or in an HMO until it has received a certificate of authority to operate and maintain the HMO from the Secretary and the Commissioner.

Source

The provisions of this § 301.41 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

Cross References

This section is cited in 31 Pa. Code § 301.301 (relating to definitions); and 31 Pa. Code § 301.303 (relating to certificate of authority).

§ 301.42. Content of application for certificate of authority.

An application for a certificate of authority under the act shall be made in writing in triplicate to the Commissioner. The application shall contain the following information:

- (1) A copy of the basic organizational documents of the applicant organization, such as the articles of incorporation and amendments thereto.
- (2) A copy of the bylaws, rules and regulations or similar documents governing the conduct of the internal affairs of the applicant corporation.

(3) A list of the names, addresses and official positions of the members of the Board of Directors of the applicant corporation and of persons who are to be responsible for the conduct of the affairs of the applicant. The list shall include the Executive Director or President, Medical Director, Director of Marketing and Director of Finance, and notarized biographical forms for each.

(4) A description of the service area of the proposed HMO, including geographic boundaries, demographic data and identification of population groups which would be sources of prepayment.

(5) Copies of the applicant corporation's proposed contracts with subscribers and groups of subscribers, including evidence of coverage forms, setting forth the corporation's contractual obligations to provide basic health services.

(6) Copies of the applicant corporation's proposed contracts with physicians, groups of physicians organized on a group-practice or individual-practice basis, hospitals, skilled nursing facilities and other providers of health care services enabling it to provide health services to a voluntarily enrolled population.

(7) Copies of a proposed contract with an individual, partnership, association or corporation for the performance on its behalf of necessary functions, including marketing, enrollment and administration of a contract with an insurance company, hospital plan corporation or professional health service corporation for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the HMO.

(8) A detailed description of the applicant corporation's proposed grievance resolution system whereby the complaints of its members may be acted upon promptly and fairly.

(9) A copy of the applicant corporation's proposed premium rates and a detailed description of the underlying assumptions utilized in deriving rates, which shall be submitted separate from the remainder of the application for certificate of authority. The actuarial methodology used in deriving premium rates may not be considered public information. The detailed description of the underlying assumptions used in deriving rates shall include:

(i) Projected hospital and skilled nursing facility inpatient utilization in days per 1,000 members per year, subdivided by age or sex.

(ii) Projected hospital costs attributable to hospitals to be specifically utilized by the HMO through contract or otherwise.

(iii) Projected outpatient and same day hospital utilization in services per 1,000 members per year, subdivided by age or sex, as applicable.

(iv) Projected outpatient and same day hospital costs attributable to hospitals to be utilized by the HMO by contract or otherwise.

(v) Projected utilization of various physician services, such as primary office, inpatient and surgical, expressed in terms of number of visits per 1,000 members per year, subdivided by age or sex.

(vi) Projected cost of physicians' services, expressed in terms of cost per visit or per service.

(vii) Identification of physician services that are included in primary care capitation, if applicable. If there is a specialist capitation, services shall be identified.

(viii) Projected cost of emergency and out-of-area services of non-HMO providers, differentiated as to hospital and medical service components.

(ix) Projected cost and utilization of other services, such as prescription drug, home health, eye or ear exams, mental health, substance abuse and medical equipment.

(x) Identification of copays, if any, and their effect on rates.

(xi) Identification of incentive arrangements and risk pool arrangements in provider agreements, and their effect on rates. The categories of provider services covered by the arrangements shall be identified.

(xii) Identification, justification and derivation of a separate trend factor. For each separate trend factor, the specific benefits to which the trend factor applies shall be identified.

(xiii) Identification and justification of reserve or surplus contribution factors.

(xiv) Identification and justification of profit factor.

(xv) Projected cost of reinsurance.

(xvi) Projected amount of investment income.

(xvii) A detailed breakdown of administration expenses into component parts including management fees.

(xviii) Identification of demographic information used to convert the total cost per member per month to the proposed premium rates.

(xix) Identification and derivation of large group rate adjustment formulas.

(xx) A rate table listing proposed premium rates by effective period, class of membership and applicable contract form number which is separate from the rate justification materials.

(xxi) Projected financial statements, including schedules of cash flow, for a number of years that go at least past the breakeven point. Assumptions underlying the financial statements, including the projected number of members, shall be included.

(10) A map of the service area showing the locations of the providers used by the HMO.

(11) A detailed description of incentives for cost control within the structure and function of the proposed HMO.

(12) A detailed description of reinsurance contracts and a description of insolvency reinsurance obtained by the HMO.

(13) A statement that no funds may be transferred out of this Commonwealth by the HMO without the prior approval and written consent of the Department.

(14) A copy of the applicant corporation's most recent financial statement.

- (15) A description of the applicant corporation's capability to collect and analyze necessary data relating to the utilization of health care services by enrolled members.
- (16) A copy of the proposed general subscriber literature.
- (17) A procedure for referral of members to nonparticipating specialists.
- (18) Written procedures for payment of emergency services provided by other than a participating provider.
- (19) A description of the manner in which members will be selected to meet the statutory requirement that 1/3 of the board members be members.
- (20) A description of the system established to ensure that the records of the corporation pertaining to its operation of an HMO are identifiable and distinct from other activities in which the corporation may engage.
- (21) Other information that the applicant corporation may wish to submit which reasonably relates to its ability to operate and maintain an HMO.
- (22) Other information which the Commissioner finds necessary to review an HMO's application.

Authority

The provisions of this § 301.42 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

Source

The provisions of this § 301.42 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807; amended September 8, 1989, effective September 9, 1989, 19 Pa.B. 3820; amended March 13, 1992, effective March 14, 1992, 22 Pa.B. 1178. Immediately preceding text appears at serial pages (143038) to (143041).

Cross References

This section is cited in 31 Pa. Code § 301.43 (relating to review by the Department); 31 Pa. Code § 301.301 (relating to definitions); and 31 Pa. Code § 301.303 (relating to certificate of authority).

§ 301.43. Review by the Department.

- (a) Before the Department issues a certificate of authority, a thorough review will be made to determine whether the proposed HMO, the plan under which it proposes to operate and the services which it proposes to provide are consistent with the act and this chapter.
- (b) Within 10 business days of receiving an application for a certificate of authority, the Department will determine whether the application contains the items listed in § 301.42 (relating to content of application for certificate of authority). If the Department determines that the application is not complete, it will send a written request to the applicant corporation stating specifically what additional information is needed.
- (c) The application for a certificate of authority will not be considered complete until the additional information is received by the Department.

(d) Upon receipt of a completed application for a certificate of authority, the Department will publish a notification of receipt of the filing in the *Pennsylvania Bulletin* in order to provide an opportunity for public comment.

(e) Within 90 days of receipt of a completed application for a certificate of authority, the Secretary and Commissioner will jointly do either of the following:

(1) Approve the application and issue a certificate of authority.

(2) Disapprove the application specifying in writing the reasons for the disapproval. Disapproval of an application may be appealed under 2 Pa.C.S. (relating to administrative agency law and procedure).

(f) The Department may conduct an examination of the books and papers of the proposed HMO to determine its financial ability to carry out its required functions.

(g) The Department may inspect the site or proposed site of the HMO's facilities to determine its ability to carry out its required functions.

(h) The Department may hold a public hearing to obtain additional information about a proposed HMO. The Department, whenever possible and appropriate, will attempt to hold joint hearings with the Department of Health.

(1) If the Department decides to hold a public hearing, notification in writing will be provided to the applicant corporation by certified mail at least 10 days prior to the hearing.

(2) Notice of the hearing will also be published in the *Pennsylvania Bulletin* at least 10 days prior to the hearing.

(3) The hearing will be conducted as soon as possible, but no earlier than 10 business days after written notice has been provided to the applicant corporation.

(i) The Department will confer with and coordinate its investigation with the Secretary.

Source

The provisions of this § 301.43 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

Subchapter D. OPERATIONAL STANDARDS FOR A HEALTH MAINTENANCE ORGANIZATION

Sec.

301.61. Operational standards.

301.62. Subscriber contracts and evidences of coverage.

301.63. Rate approvals.

301.64. Solicitors and agents.

301.65. Transfer of funds.

§ 301.61. Operational standards.

A corporation receiving a certificate of authority to establish and operate an HMO under the act shall provide quality health care services in a cost-effective manner and in a manner which does not impair the corporation's ability to deliver, arrange for the delivery of or pay for health services for its members.

Authority

The provisions of this § 301.61 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

Source

The provisions of this § 301.61 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807; amended September 8, 1989, effective September 9, 1989, 19 Pa.B. 3820. Immediately preceding text appears at serial page (115168).

§ 301.62. Subscriber contracts and evidences of coverage.**(a) General filing procedure.**

(1) *Number of copies.* The HMO shall file group and nongroup contract forms and evidences of coverage, in duplicate. One copy will be retained by the Department, and the other copy will be returned to the HMO with the action taken by the Department noted thereon.

(2) *Time of filing.* Contract forms and evidences of coverage shall be filed with the Commissioner and deemed approved unless explicitly rejected within 60 days of the filing. Disapproval of a filing by the Commissioner may be appealed under 2 Pa.C.S. (relating to administrative law and procedure).

(3) *Form number.* A form shall be identified with a distinguishing form number on the cover of the form.

(4) *Hypothetical data.* Blank spaces in the proposed contract form and evidence of coverage shall be completed with hypothetical data demonstrating the purpose and use of the forms.

(5) *Final print required.* Contract forms and evidences of coverage shall be submitted in final print, in the form intended for actual issue, for formal filing. Initial submissions of contract forms and evidences of coverage may be in other than final print when the HMO desires a preliminary review of forms before preparing final printed documents.

(6) *Letter of submission.* The letter of submission shall be in duplicate and shall contain:

- (i) The form number of each form submitted.
- (ii) An explanation of the coverage provided.
- (iii) An explanation of the specific purpose and use of the form.
- (iv) Identification of the previously approved form which is to be replaced by the newly submitted form.
- (v) Identification of forms no longer being used by the HMO.

(b) *Disclosure requirements.*

(1) Contract forms and evidences of coverage shall clearly and prominently state that coverage is limited to services provided by affiliated providers, except in emergency situations or when authorized in advance by an affiliated provider.

(2) Contract forms and evidences of coverage shall clearly explain the limitations on emergency and out-of-area services.

(3) Contract forms and evidences of coverage shall contain a complete, accurate and easily understood description of contract benefits, limitations and exclusions.

(4) Contract forms and evidences of coverage shall state that changes in premium rates and contract forms are subject to prior review and approval by the Department.

(c) *Emergency benefits and services.* The contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies 24 hours a day, 7 days a week, including disclosure of restrictions on emergency benefits and services. The forms shall explain the procedures to be followed to secure medically necessary emergency health services. Emergency care service shall be covered in and out of the service area. No contract or evidence of coverage may limit the availability of emergency services within the service area only to affiliated providers. No emergency room copayment in excess of primary care copayment may be charged if the member has been referred to the emergency room by a primary care physician or the HMO and the services could have been provided in the primary care physician's office.

(d) *Copayment requirements.* Contract forms, evidences of coverage and marketing literature shall contain a complete, accurate and easily understood description of copayment requirements. Copayments shall be described in specific dollar amounts.

(e) *Arbitration.* Contract forms and evidences of coverage may not require a member to submit to binding arbitration for settlement of a dispute between the member and the HMO.

(f) *Subrogation.* If the contract contains a subrogation or reimbursement provision, the provision shall state that the right of subrogation or reimbursement is not enforceable if prohibited by statute or regulation.

(g) *Transplant procedures.* Benefits for a covered transplant procedure shall include coverage for the medical expenses of a live donor to the extent that those medical expenses are not covered by another program.

(h) *Preexisting conditions.*

(1) No preexisting condition limitation provision may be more restrictive than the following:

(i) A preexisting condition is a disease or physical condition for which an individual received medical advice or treatment within 90 days immediately prior to becoming covered under the contract.

(ii) The condition shall be covered in full after the individual has been covered under the contract for 12 months.

(2) Group contracts shall give the member credit toward satisfaction of the preexisting condition limitation for the period of time the member was covered by the group's prior health care plan or alternate health care plan.

(3) Nongroup conversion contracts shall give the member credit toward satisfaction of the preexisting condition limitation for the period of time the member was covered by the prior group contract.

(4) If a contract includes a preexisting condition limitation, the enrollment form shall contain a question and provision for answer in the following form: "NOTICE: The following question must be answered: Do you understand that the HMO will not provide coverage during the first- _____ month(s) of enrollment for health care services required for the treatment of any disease or physical condition which required medical advice or treatment within 90 days prior to enrollment?"

(5) Contracts may not utilize individual impairment riders whereby coverage for a specific condition of a specific individual is limited or excluded.

(i) *Termination of coverage.*

(1) The contract and evidence of coverage shall clearly state the conditions upon which cancellation or termination may be effected by the HMO or the member.

(2) No HMO may cancel or terminate coverage of services provided a member under an HMO contract except for one of the following reasons:

(i) Failure to pay the amounts due under the contract.

(ii) Fraud or material misrepresentation in the use of services or facilities.

(iii) Violation of the material terms of the contract.

(iv) Failure to continue to meet the eligibility requirements under a group contract, if a conversion option is offered.

(v) Termination of the group contract under which the member was covered.

(vi) Failure of the member and the primary care physician to establish a satisfactory patient-physician relationship if:

(A) It is shown that the HMO has, in good faith, provided the member with the opportunity to select an alternative primary care physician.

(B) The member has repeatedly refused to follow the plan of treatment ordered by the physician.

(C) The member is notified in writing at least 30 days in advance that the HMO considers the patient-physician relationship to be unsatisfactory and specific changes are necessary in order to avoid termination subject to HMO grievance procedure.

(vii) Another reason approved by the Commissioner.

(3) No HMO may cancel or terminate a member's coverage for services provided under an HMO contract on the basis of the status of the member's health.

(4) No HMO may cancel or terminate a member's coverage for services provided under an HMO contract on the basis that the subscriber has exercised rights under the HMO's grievance system by registering a complaint against the HMO.

(5) No HMO may cancel or terminate a member's coverage for services provided under an HMO contract without giving the member written notice of termination including the reason for termination. Termination is not effective for at least 15 days from the date of mailing. If the notice is not mailed, effective termination is from the date of delivery. For termination due to nonpayment of premium, the grace period shall be at least 30 days.

(6) A member's misuse of a membership card will not result in termination of coverage for the member's entire family unless the member who misuses the membership card is the subscriber.

(7) A member's failure to establish and maintain an acceptable physician-patient relationship with a provider will not result in termination of coverage for the member's entire family unless the member is the subscriber.

(8) If a member is an inpatient in a hospital or skilled nursing facility on the date coverage is due to terminate, coverage shall be extended until the member is discharged from the hospital or skilled nursing facility, but may be terminated when the contractual benefit limit has been reached.

(j) *Coordination of benefits.* The contract and evidence of coverage may contain a provision for coordination of benefits that shall be consistent with that applicable to other carriers in this Commonwealth. Provisions or rules for coordination of benefits established by an HMO may not relieve an HMO of its duty to provide or arrange for a covered health care service to a member because the member is entitled to coverage under another contract, policy or plan, including coverage provided under government programs. The HMO is required to provide health care services first and then may seek coordination of benefits.

(k) *Grace period.* The contract or evidence of coverage shall provide for a grace period of at least 30 days for the payment of premiums, except the first, during which coverage shall remain in effect. The contract holder shall remain liable for:

(1) The payment of the premium for the time coverage was in effect during the grace period.

(2) The member shall remain liable for copayments owed.

(l) *Claims.* The contract and evidence of coverage shall contain procedures for filing claims that include:

(1) A required notice to the HMO.

(2) How and when claim forms are obtained if they are required.

(3) Requirements for filing proper proofs of loss.

(4) A time limit for payment of claims.

(m) *Medical necessity administration.* Authorization by the member's primary care physician, or other physician providing service at the direction of the primary care physician, shall constitute proof of medical necessity for purposes of determining a member's potential liability.

Authority

The provisions of this § 301.62 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

Source

The provisions of this § 301.62 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807; amended September 8, 1989, effective September 9, 1989, 19 Pa.B. 3820. Immediately preceding text appears at serial pages (115168) to (115172).

§ 301.63. Rate approvals.

(a) Rates charged members or groups of members shall be filed with the Commissioner and be deemed approved unless explicitly rejected within 60 days of receipt of the filing by the Department. Disapproval of a rate filing by the Commissioner may be appealed under 2 Pa.C.S. (relating to administrative law and procedure).

(b) Rate filings shall describe the benefit package, identify the class of membership—for example, group, group conversion, nongroup and the like—and indicate the form number of the contract form to which the proposed premium rates will apply.

(c) Rate filings shall indicate the period during which the proposed premium rates will be effective for issues and renewals and the period for which the rates will be contractually guaranteed.

(d) Rate filings shall indicate the effective date of the last rate revision.

(e) Rate filings shall state the percentage by which the proposed rates exceed the current rates.

(f) Rate filings shall describe the procedure and identify the assumptions used to convert the total cost per member per month to the proposed premium rates. This includes the current and proposed assumptions for premium structure—ratio of family premium to single and the like—for distribution of contracts, and for number of members per contract.

(g) Rate filings shall describe the procedure and identify the inflationary trend factors used to project the proposed premiums from the initial rating period to each succeeding rating period.

(h) Rate filings shall list, for every claim component utilized by the HMO constructing the proposed premium rates, the assumed utilization, the average unit cost and the cost per member per month. Assumptions for expenses, profits, incentive margins, specialist and primary care capitations and similar items shall

also be defined and listed. The rate filing shall compare in tabular fashion these assumptions with the corresponding assumptions used in calculating the current premium rates and with the actual experience data. The experience period shall be identified. Assumptions and trend factors for the proposed premium rates shall be identified and justified by using the current assumptions and the experience data. The hospital unit component shall be subdivided by hospital.

(i) For contractual capitation arrangements, rate filings shall indicate the effective and termination dates of the current contracts, the current capitation amounts and the proposed capitation amounts for contracts due to be renewed during the rating period. Filings shall identify the premium rate components which in total equal the average capitation amounts paid to providers.

(j) Rate filings shall show the number of contract months and member months exposed during the experience period.

(k) Rate filings shall show the total number of members for the four most recent calendar quarters available and the projected number of members by quarter during the rating period.

(l) Proposed premium rates shall be shown in a table which is separate from the other information in the rate filing.

Authority

The provisions of this § 301.63 amended under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Health Maintenance Organization Act (40 P. S. §§ 1551—1567).

Source

The provisions of this § 301.63 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807; amended September 8, 1989, effective September 9, 1989, 19 Pa.B. 3820. Immediately preceding text appears at serial pages (115172) and (126484).

§ 301.64. Solicitors and agents.

Solicitors and agents for an HMO shall be licensed as, and subject to the statutes pertaining to, insurance agents.

Source

The provisions of this § 301.64 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

§ 301.65. Transfer of funds.

(a) No funds, except for the purchase of goods and contracted services, may be transferred out of this Commonwealth by an HMO without the prior approval and written consent of the Department.

(b) A licensed HMO may continue to transfer funds in accordance with a procedure or system which was in operation on February 21, 1987, if it submits for the Department's review a complete and accurate description of the transfer

procedure by April 22, 1987. If the Department disapproves of the transfer procedure and system, the HMO will be notified in writing, specifying the reason for the disapproval. The HMO will be permitted a reasonable period of time, to be identified in the notice of disapproval but not less than 45 days, in which to discontinue the transfers and return funds to this Commonwealth.

Source

The provisions of this § 301.65 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

Cross References

This section cited in 31 Pa. Code § 303.1 (relating to review of requests of health maintenance organizations to transfer funds out of this Commonwealth—statement of policy).

Subchapter E. CONTINUING SUPERVISION OF OPERATIONAL HEALTH MAINTENANCE ORGANIZATIONS

Sec.

- 301.81. Financial reports.
- 301.82. Departmental investigation.
- 301.83. Federally qualified HMOs.
- 301.84. Exceptions.

§ 301.81. Financial reports.

(a) An HMO shall submit to the Department before March 1 of each year an annual financial report for the preceding calendar year in a form prescribed by the Commissioner.

(b) During the initial 5 years of operation, an HMO shall submit to the Department quarterly financial reports in a form prescribed by the Commissioner. The reports shall be submitted within 45 days following the end of a calendar quarter.

Source

The provisions of this § 301.81 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

§ 301.82. Departmental investigation.

(a) The Department may investigate further information contained in or forming the basis of reports submitted according to this chapter.

(b) Investigation may include onsite inspection of the HMO's facilities and records of the HMO.

(c) The Commissioner or an agent shall have free access to the books, records, papers and documents that relate to the business of the HMO.

(d) The Department may charge the HMO for the services of its examiners in the manner it charges insurance companies as prescribed in section 216 of The Insurance Department Act of one thousand nine hundred and twenty-one (40 P. S. § 54) and under the funding requirements set forth by the National Association of Insurance Commissioners (NAIC).

Source

The provisions of this § 301.82 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

§ 301.83. Federally qualified HMOs.

(a) In applying this chapter to Federally-qualified HMOs, the Department may take into account the extent of compliance with Federal standards.

(b) If there is a conflict or potential conflict between this chapter and Federal regulations applicable to Federally-qualified HMOs, the Department will coordinate directly with the appropriate Federal authority to attempt to remove or resolve the conflict.

Source

The provisions of this § 301.83 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

§ 301.84. Exceptions.

(a) The Department may, for good cause and only if financial viability of the HMO or the welfare of a citizen would not be impaired, grant exceptions to this chapter when the policy objectives and intentions of this chapter are otherwise substantially met.

(b) A request for exceptions to this chapter shall be made in writing to the Department. A request, whether approved or not, will be retained on file by the Department. An approved request shall be retained on file by the corporation during the period the exception remains in effect.

(c) An exception granted under this chapter may be revoked by the Department for good cause whenever the policy objectives and reasons for granting the exception will no longer be furthered.

(d) The Department will give written notice by certified mail, return receipt requested, revoking an exception and will state the reason for its action and a specific date upon which the exception will be terminated.

(e) The Department will provide for a reasonable time between the date of written notice of revocation and the date of termination of an exception for the HMO from compliance with this chapter.

(f) Failure of the HMO to comply by the specified date may result in action to revoke the previously approved certificate of authority.

(g) The Department's denial or revocation of an exception is a final agency action and is appealable under 2 Pa.C.S. §§ 701—704 (relating to judicial review of Commonwealth agency action).

Source

The provisions of this § 301.84 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

Subchapter F. PENALTY PROVISIONS

Sec.
301.101. Violations.

§ 301.101. Violations.

A violation of this chapter is punishable under section 15 of the act (40 P. S. § 1565) and other applicable statutes of the Commonwealth.

Source

The provisions of this § 301.101 adopted February 20, 1987, effective February 21, 1987, 17 Pa.B. 807.

Subchapter G. PROTECTION AGAINST INSOLVENCY

Sec.
301.121. Protections against insolvency.
301.122. Hold harmless.
301.123. Continuation of benefits.
301.124. Notice of provider termination.
301.125. Replacement coverage.
301.126. HMO insolvency group.

Source

The provisions of this Subchapter G adopted March 13, 1992, effective March 14, 1992, 22 Pa.B. 1178, unless otherwise noted.

§ 301.121. Protections against insolvency.

(a) A new certificate of authority filing shall include procedures to be implemented to meet the requirements for protection against insolvency.

(b) Requirements for protection against insolvency include:

(1) For new plans filing for a certificate of authority, a minimum initial net worth of \$1.5 million.

(2) For every operational HMO, minimum net worth equal to the greater of \$1 million or 3 months uncovered health care expenditures for Pennsylvania enrollees as reported on the most recent financial statement filed with the

Commissioner. A dedicated funding commitment, such as an irrevocable letter of credit or other instrument from a parent company, may be considered in assessing net worth, if approved by the Commissioner. This commitment would not be considered a substitute for a capital infusion needed to obtain a positive net worth.

(c) Existing HMOs have 4 years to meet the net worth requirements, in increments of \$250,000 as of January 1 of each year. The plan is required to include the uncovered expenses amount, if applicable, in the fifth year.

(d) Interest expenses relating to the repayment of a fully subordinated debt are considered a covered expense.

(e) Fully subordinated debt is not considered a liability.

(f) An HMO shall deposit with the Commissioner cash, securities or a bond, or an acceptable combination, which has a value of at least \$100,000. The deposit shall cover administrative costs in the event of liquidation.

(g) The deposit, as required in subsection (f), is an admitted asset of the HMO in the determination of net worth.

(h) Income from deposits is an asset of the organization. An HMO that has made a securities deposit could withdraw that deposit or a part thereof after making a substitute deposit of cash, securities, or a combination of these, or other instruments of equal amount and value.

(i) The Commissioner may reduce or eliminate the deposit requirement if the HMO deposits with the State Treasurer, the Commissioner or other official body of the state of the HMO's domicile for the protection of all subscribers and enrollees of the HMO, wherever located, cash, acceptable securities or surety, and delivers to the Commissioner a certificate to that effect, authenticated by the appropriate state official holding the deposit.

(j) An HMO investment is subject to the investment provisions for a stock life company in sections 404.1 and 404.2 of The Insurance Company Law of 1921 (40 P. S. §§ 504.1 and 504.2).

§ 301.122. Hold harmless.

A contract between an HMO and a participating provider of health care services shall include a provision to the following effect:

“(Provider) hereby agrees that in no event, including, but not limited to non-payment by the HMO, HMO insolvency or breach of this agreement, shall (Provider) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than HMO acting on their behalf for services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on the HMO's or provider's behalf made in accordance with the terms of the applicable agreement between the HMO and subscriber/enrollee.

“(Provider) further agrees that (1) the hold harmless provisions herein

shall survive the termination of the (applicable Provider contract) regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

“Any modification, addition, or deletion to the provisions of this section shall become effective on a date no earlier than fifteen (15) days after the Secretary of Health has received written notice of such proposed changes.”

Cross References

This section is cited in 31 Pa. Code § 301.314 (relating to Department review).

§ 301.123. Continuation of benefits.

(a) An HMO shall have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until either their discharge or expiration of benefits—limited to services directly related to the condition which occasioned the admission—whichever comes later. This plan may limit the continuation of benefits to the expiration of the member’s benefits if the member or the contractholder, for example, employer, has an opportunity to obtain replacement coverage under § 301.125 (relating to replacement coverage), and fails to obtain replacement coverage.

(b) The Commissioner may require one or more of the following which provides for continuation of benefits:

(1) Insurance to cover the expenses for continued benefits after an insolvency, including conversion contracts. The HMO shall provide evidence of an agreement by the insurer to notify the Commissioner within 10 days of the insurer’s intent to terminate for any reason, including failure to pay the premium.

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the HMO’s insolvency for which premium payment has been made and until the enrollee’s discharge from the inpatient facility. The provisions may limit the continuation of benefits to the expiration of the member’s benefits if the member or the contractholder, for example, employer, has an opportunity to obtain replacement coverage under § 301.125, and fails to obtain replacement coverage.

(3) Acceptable letters of credit.

(4) Dedicated parental guaranty in a form and amount approved by the Commissioner.

(5) Other arrangements approved by the Commissioner to assure that benefits are continued as specified in this section.

Source

The provisions of this § 301.123 adopted March 13, 1992, effective March 14, 1992, 22 Pa.B. 1178; corrected April 24, 1992, effective March 14, 1992, 22 Pa.B. 2242.

§ 301.124. Notice of provider termination.

An agreement to provide health care services between a provider and an HMO shall require that if the provider terminates the agreement, the provider shall give the HMO at least 60 days' advance notice of termination.

Notes of Decisions*Notice*

Regulatory notice was unnecessary once the contract between the hospital and the insurance company expired, rather than terminated, because the parties already approved the expiration and, thus, providing "notice" of the contract's expiration would simply inform the party of a contractual term which it has already approved. *Children's Hospital of Philadelphia v. Independence Blue Cross*, 89 F. Supp. 2d 630 (E. D. Pa. 2000).

§ 301.125. Replacement coverage.

If an impairment or insolvency of an HMO exists the following requirements shall be met:

(1) Other carriers who participated in the enrollment process with the impaired or insolvent HMO at a group's last regular enrollment period, and which currently provide coverage to one or more employees of that group, shall offer the enrollees of the impaired or insolvent HMO a 15 business day enrollment period commencing upon the date of the mailing of the notification to subscribers of the impairment or insolvency.

(2) A carrier shall offer the enrollees of the impaired or insolvent HMO the same coverage and rates which the carrier currently offers to the enrollees for the group. The carrier shall immediately cover the employees and dependents who were validly covered under the previous HMO contract or policy as of the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of provisions in the contract relating to active employment, hospital confinement or other pre-existing health conditions.

(3) The receiving HMO may not become primary for expenditures which should be covered under the impaired or insolvent HMO's continuation of benefits coverage.

(4) An open enrollment period will be preceded by at least 30 days notice from the Commissioner to each affected plan.

(5) An HMO shall provide the Department with evidence of a contractual arrangement with an insurer or hospital service corporation to provide conversion coverage in the event of the HMO's impairment or insolvency.

Cross References

This section cited in 31 Pa Code § 301.123 (relating to continuation of benefits).

§ 301.126. HMO insolvency group.

At the time of HMO impairment, the Department may appoint a team of HMO managers to work under the direction of State regulatory personnel and the management of the impaired HMO to develop a viable plan to restore, rehabilitate, reorganize or otherwise deal with the problem and protect the subscribers of the

impaired plan. The group will serve in an advisory capacity to the Commissioner. Members of the group will be selected by the Commissioner from plans that did not compete with the impaired plan. Suggested members of the team will include representatives of general management, marketing, finance and health care delivery systems.

**Subchapter H. POINT-OF-SERVICE PRODUCTS GROUP
SPECIFIC COMMUNITY RATING—
STATEMENT OF POLICY**

Sec.

301.201. General.

301.202. Financial requirements—point-of-service products.

301.203. Filing requirements.

301.204. Group specific community rating for HMOs.

§ 301.201. General.

An HMO point-of-service product filing or a group specific community rating filing complying with standards in this chapter is acceptable.

Source

The provisions of this § 301.201 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

§ 301.202. Financial requirements—point-of-service products.

(a) *Minimum net worth compliance.*

(1) HMOs offering point-of-service products will be assuming additional indemnity-type financial risk. To adequately protect HMO members enrolled in point-of-service products and to ensure HMO ability to pay indemnity claims for covered services rendered by out-of-network providers, each HMO desiring to offer a point-of-service product shall first present satisfactory evidence of having a minimum net worth of the highest of \$1.5 million of 2% of premiums, or an amount equal to the sum of 3 months uncovered health care expenditures as reported on the most recent financial statement filed with the Insurance Department. The evidence shall be presented to the Insurance Department's Bureau of Licensing and Financial Analysis, Office of the Regulation of Companies.

(2) Upon satisfactory compliance with this requirement, an HMO may then make an appropriate program filing with the Department's Office of Rate and Policy Regulation, Division of HMOs/PPOs and to the Bureau of Health Financing and Program Development of the Health Department.

(b) *Adequate reserving requirements.*

(1) An important component of financial integrity of a point-of-service product is the ability of an HMO to monitor adequately incurred but not reported claims (IBNR) and adequately reserve for the liabilities.

(2) An HMO receiving approval to offer a point-of-service product shall establish and maintain specified reserves for uncovered expenditures—that is, expenditures owed to nonparticipating providers not having contracts with the HMO which includes NAIC/NAHMOR financial hold harmless language—greater than the most recent 3 months of out-of-network (swing out) claims paid.

(3) Each HMO gaining approval to offer a point-of-service product shall submit to the Department's Bureau of Licensing and Financial Analysis on a quarterly basis evidence that it has met this requirement and established sufficient reserves.

(4) The Department and the Department of Health (the Departments) may suspend the HMO's authority to enroll additional members in point-of-service products if it fails to maintain the minimum net worth requirements as set forth in subsections (a) and this subsection. Failure of the HMO to correct a reserve deficiency promptly may result in withdrawal of its authority to offer a point-of-service product.

(c) *Limits on out-of-network usage/expenses.*

(1) It is the Department's interpretation of the act that, while HMOs may be permitted to offer point-of-service products, the primary business of an HMO should remain the provision and financing of basic health services through the HMO's organized health services delivery system centered around each member's voluntarily selected primary care physician (PCP).

(2) Therefore, the Departments are establishing a 10% target limit for out-of-plan usage.

(3) The 10% target limit shall be calculated as follows for each reporting period:

Total point-of-service out of network claims incurred by the HMO for the reporting period.

Divided by:

Total of all claims incurred by the HMO for the reporting period.

Equals:

The target percentage

(i) The target percentage shall be calculated and reported to the Departments on a quarterly basis.

(ii) If the target percentage exceeds 10%. The HMO shall include with its submission of the target percentage calculation:

(A) An explanation of why and how out-of-plan utilization has exceeded 10%.

(B) What steps will be taken during the following reporting period to bring out-of-plan utilization to within the target percentage.

(iii) The Departments may suspend the HMO from enrolling additional members in the point-of-service product if the target percentage exceeds 10% for more than 3 consecutive quarters.

(iv) The Departments will compare reported estimated expenditures with actual expenditures. Variations between estimated and actual expenditures may result in suspension of the HMO's authority to offer a point-of-service product.

Source

The provisions of this § 301.202 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

Cross References

This section cited in 31 Pa. Code § 301.203 (relating to filing requirements).

§ 301.203. Filing requirements.

(a) Along with the submission of adequate reserving methodology, an HMO shall submit a formal product filing to the Division of HMOs/PPOs of the Department and the Bureau of Health Financing and Program Development of the Department of Health.

(b) HMOs will be permitted to offer a point-of-service product subject to the following conditions.

(1) Filing requirements—all products:

(i) Two copies shall be submitted to each Department.

(ii) The filing shall include an appropriate rate filing.

(iii) The filing should contain incentives for HMO members to utilize basic HMO services, stay within the HMO panel of participating providers, and utilize the services of designated primary care physicians. Minimum requirements for indemnity reimbursement for out-of-network claims should be:

(A) Minimum deductible of \$250 per individual/\$500 per family per calendar year.

(B) Minimum coinsurance of 20%.

(C) Total out-of-pocket expenses for use of nonnetwork providers should be in the following ranges:

(I) Individual annual out-of-pocket expense, excluding calendar year deductible: minimum—\$2,000; maximum—\$5,000.

(II) Family annual out-of-pocket expense, excluding calendar year deductible: minimum—\$4,000; maximum—\$10,000.

(III) The lifetime maximum for point-of-service out-of-network claims per person shall be at least \$250,000.

(iv) Clear and adequate disclosure is an absolute necessity because of the complexity of the point-of-service product and great potential for enroll-

ees to misunderstand it. The evidence of coverage shall contain adequate disclosure of coverage limitations and conditions, including member liability for deductibles, copayments and differences between the HMO's UCR reimbursement and actual charges of out-of-network providers.

(v) Primary care services shall only be reimbursable within the HMO network when rendered at or by direction of the member's primary care physician. Primary care services shall be services which the primary care physician is requested to provide under the provisions of the contract with the HMO.

(vi) An HMO may require precertification of out-of-network nonemergency hospital admissions.

(vii) Emergency coverage shall be provided under provisions of the basic HMO coverage without application of out-of-network deductibles or coinsurance.

(viii) The filing shall include an explanation of how the HMO will meet its continuity of care requirements under the act and 28 Pa. Code (relating to health and safety).

(ix) The HMO shall require that either the member's PCP or the HMO itself issue a claim form or other notice for use by the member in claiming reimbursement for out-of-network care. The claim form or other notice shall be submitted for review and approval of the Departments and the Department of Health. The claim form or notice shall require the signature of the member and contain adequate disclosure that the member understands that by voluntarily seeking care out-of-network the member is assuming substantial financial liability for the care, and that the care if provided within the HMO network would be provided at a much lower out-of-pocket expense to the member.

(x) The HMO is responsible for furnishing claims information to the primary care physician concerning the member's usage of out-of-network health services. The objective of this requirement is to provide critical information to the patient's primary care physician so that when the member returns in-network, the PCP has adequate knowledge to maintain continuity of care.

(xi) Other methods to accomplish the objective in subparagraph (x) may be proposed in the filing and will be reviewed on a case by case basis.

(xii) An information system shall be included by which the HMO will track the claims payments by PCP for out-of-network services. The HMO shall commit itself to monitoring out-of-network usage and to promptly investigate any PCP practice whose enrolled members are utilizing substantially higher levels of out-of-network care than average. Therefore, written policies and procedures shall be included in the filing to ensure that PCPs are not subtly or otherwise encouraging members to use out-of-network providers.

(xiii) The filing shall describe in detail the HMO's claims payment system. This description shall include staffing for paying out-of-network indemnity claims and capability for establishing adequate tracking, estimation and reserving for incurred but not reported claims.

(xiv) The HMO's data/information system shall be capable of paying out-of-network claims in a timely manner, tracking incurred but not reported expenses, adequately forecasting projections, calculating the 10% limit, adequately interfacing between membership and eligibility files and between the HMO's systems and those of an applicable affiliated insurer, and generating required Department reports.

(xv) Nongroup conversions are not required to include a point-of-service benefit.

(xvi) Approvals for point-of-service products will be subject to a 1-year probationary period during which time the HMO will have to establish a track record of successfully administering a point-of-service product. During the 1-year probationary period, enrollment in the point-of-service may not exceed 5% of the HMO's private sector enrollment.

(b) Additional filing requirements for products in which the out-of-network indemnity benefits are to be underwritten by an HMO affiliated insurer, which is any carrier other than the HMO itself proposing to supplement the HMO's standard coverage by providing out-of-network benefits are:

(1) The filing shall be made by the HMO.

(2) The filing shall include:

(i) Copies of the previously approved group contract and certificate.

(ii) Copies of amendments necessary or desirable thereto to integrate the services to be provided by the HMO and paid for by the affiliate insurer.

(iii) Copies of the affiliated insurers group master contract and certificate.

(iv) Enrollment material and enrollee literature.

(v) The certificates and enrollee literature that adequately explain how the program will operate.

(vi) A copy of the contract between the HMO and affiliated insurer detailing their respective responsibilities and obligations in offering a point-of-service product.

(3) The HMO shall include in its rate filing the rate level justification and a demonstration of how the out-of-network indemnity benefits to be provided by the affiliated insurer will impact on the HMO's rates and underlying utilization assumptions.

(4) To lessen confusion on the part of members, out-of-network claims shall be initially filed with the HMO. Additionally, the member point of contact regarding out-of-network benefits shall always be with the HMO.

(5) Grievances, including those concerning coverage or claim denial under the out-of-network benefit program, shall be subject to and decided by the HMO's approved grievance system and procedures.

(6) The affiliated insurer and joint product shall comply with this subchapter except for the financial reserving requirements of § 301.202(b) (relating to financial requirements—point-of-service products).

(7) The HMO is responsible for utilization management activities, not the affiliated insurer.

Source

The provisions of this § 301.203 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

§ 301.204. Group specific community rating for HMOs.

(a) HMOs will be permitted by the Department to use group specific community rating subject to the methodology in the proposed regulations published by the Health Care Financing Administration in *Federal Register*, Vol. 56, Number 133 at page 31597, July 11, 1991 (to be codified at 42 CFR 417.104(b)(2)(ii)) or in a final adopted regulation if there is a change in this section.

(b) In addition to the Federal standards, an HMO shall also meet the following conditions to use group specific community rating in this Commonwealth:

(1) The HMO shall demonstrate that it has the capability to capture claims data on a group specific basis.

(2) Group specific community rating will only be applicable to groups that have an enrollment in the HMO of at least 250 employees for the most current 12-month period. An HMO may set the minimum size requirement at a higher level than 250 enrolled employees. The minimum size requirement applies to each HMO product sold to the group.

(3) Once an HMO elects to use group specific community rating, it shall use the method for all groups that meet the minimum size requirement established by that HMO and approved by the Department.

(4) The HMO shall have covered the group for at least 36 consecutive months.

Source

The provisions of this § 301.203 adopted September 27, 1991, effective September 28, 1991, 21 Pa.B. 4424.

**Subchapter I. CONTRACTUAL ARRANGEMENTS BETWEEN HMOs
AND IDSs—STATEMENT OF POLICY**

GENERAL PROVISIONS

Sec.

- 301.301. Definitions.
- 301.302. Applicability and purpose.
- 301.303. Certificate of authority.

CONTRACT FILINGS AND OTHER REPORTING

- 301.311. Annual and quarterly filings.
- 301.312. Initial contract filing.
- 301.313. Filings upon contract changes.
- 301.314. Department review.

DEPARTMENT EXAMINATIONS

- 301.321. Department examinations of HMOs.

Source

The provisions of this Subchapter I adopted April 5, 1996, effective April 6, 1996, 26 Pa.B. 1636, unless otherwise noted.

Cross References

This subchapter cited in 28 Pa. Code § 9.401 (relating to applicability and purpose).

GENERAL PROVISIONS

§ 301.301. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Contract—An arrangement between an HMO and a risk-bearing IDS, whereby the IDS is obligated to perform marketing, enrollment, administrative or similar functions. Administrative functions do not include quality assurance, utilization review, credentialing, provider relations or related functions.

Examination Law—Sections 901—1013 of The Insurance Company Law of 1921 (40 P. S. §§ 323.1—324.13).

HMO—Health Maintenance Organization—An organized system which combines the delivery and financing of health care and the provision of basic health services to voluntarily enrolled members for a fixed prepaid fee, and is

required to obtain a certificate of authority in accordance with applicable statutes and regulations (See sections 4 and 5.1 of the act (40 P. S. §§ 1554 and 1555.1) and §§ 301.41 and 301.42 (relating to prohibition against uncertified HMOs, and content of application for certificate of authority).

IDS—Integrated Delivery System—A partnership, association, corporation or other legal entity which enters into a contractual arrangement with an HMO; employs or has contracts with providers (participating providers); and agrees under its arrangements with an HMO, to provide or arrange for the provision of a defined set of health care services to HMO members covered under an HMO benefits contract principally through its participating providers, assumes under the arrangements some responsibility for conduct, in conjunction with the HMO and under compliance monitoring of the HMO, of quality assurance, utilization review, credentialing, provider relations, or related functions, may perform claims processing and other functions and which assumes to some extent, through capitation reimbursement or other risk-sharing arrangements, the financial risk for provision of these services to HMO members.

Provider—A “health care facility” or “health care provider” as those terms are defined under section 802(a) of the Health Care Facilities Act (35 P. S. § 448.802(a)), a mental health facility licensed by the Department of Public Welfare, or an individual licensed by the Commonwealth to practice a profession involved in the healing arts. The term includes hospitals, mental health treatment facilities, drug and alcohol treatment facilities, physicians, dentists, podiatrists, psychologists, nurses, physician assistants, certified registered nurse practitioners, physical therapists, chiropractors, optometrists and pharmacists.

Risk—The possibility of financial loss associated with contracts to perform a defined set of health care services for a predetermined portion of premium dollars.

§ 301.302. Applicability and purpose.

(a) This subchapter applies to HMOs which enter into contracts with risk-bearing IDSs.

(b) This subchapter provides guidance to HMOs desiring to enter into contracts with risk-bearing IDSs for the performance of a defined set of health care services. This subchapter suggests safeguards to be adhered to by HMOs to protect HMO members against the threat posed by financially troubled or insolvent IDSs.

(c) This subchapter is not applicable to HMOs that enter into agreements with persons or entities other than IDSs for the performance of claims processing, administrative services, marketing, enrollment and other related functions.

§ 301.303. Certificate of authority.

(a) HMOs are required to obtain a certificate of authority issued jointly by the Department and the Department of Health in accordance with applicable statutes

and regulations. See sections 4 and 5.1 of the act (40 P. S. §§ 1554 and 1555.1) and §§ 301.41 and 301.42 (relating to prohibition against uncertified HMOs; and content of application for certificate of authority).

(b) Under the act, persons or entities are acting as an HMO and are obligated to obtain a certificate of authority if the person or entity directly or through arrangements with others does the following:

(1) Solicits or enrolls members in a plan that will deliver prepaid basic health services.

(2) Delivers prepaid basic health services to those members.

(c) If a person or entity is delivering prepaid basic health services to HMO members, but not soliciting or enrolling members in a plan, that person or entity is not required to obtain a certificate of authority. If the person or entity is delivering prepaid basic health services and performing administrative services or other similar functions, but not soliciting or enrolling HMO members, that person or entity is not required to obtain a certificate of authority.

CONTRACT FILINGS AND OTHER REPORTING

§ 301.311. Annual and quarterly filings.

(a) HMOs are obligated to file annual financial statements with the Commissioner, and other reports upon the Department's request, under section 11 of the act (40 P. S. § 1561).

(b) It has been the Department's practice to require the filing of quarterly financial statements by HMOs, under the authority contained in section 11 of the act.

(c) Under this authority, the Commissioner will require that HMOs which enter into contracts with IDSs, file a written report at the same time as the filing of the HMO's annual financial statement in a form which will be available from the Department.

Cross References

This section is cited in 28 Pa. Code § 9.404 (relating to financial protection of HMO members served through IDSs).

§ 301.312. Initial contract filing.

(a) An HMO shall file with the Department any contract entered into with an IDS under which the IDS will assume risk and perform other functions as indicated in section 8(b) of the act (40 P. S. § 1558(b)).

(b) Under this authority, the Commissioner will require that when an HMO initially enters into a contract with an IDS, the HMO shall file the contract with the Department not later than the filing of the next quarterly or annual financial statement, whichever occurs first, following the effective date of the contract, together with a written report in a form which will be available from the Department.

(c) If no quarterly financial statement is required by the Department, the Department requests that contracts with an IDS, together with a written report, be filed within 45 days of the effective date of the contract.

(d) Initial contract filings may be submitted with any additional information that may be appropriate for the Department's review, such as a cover letter describing the following:

- (1) The extent to which functions are transferred to the IDS and the extent and type of services which will be provided by the IDS.
- (2) The relationship between the IDS and the participating providers, and the manner in which services will be delivered by participating providers.
- (3) The identities of IDS subcontractors.
- (4) The reimbursement methodology, and a copy of security arrangements relating thereto, between the HMO and IDS.

Cross References

This section is cited in 31 Pa. Code § 301.313 (relating to filings upon contract changes).

§ 301.313. Filings upon contract changes.

(a) If a contract filed under § 301.312(a) (relating to initial contract filing) is amended, the HMO shall file the amended contract with the Department not later than the filing of the next quarterly or annual financial statement, whichever occurs first, following the effective date of the amendment.

(b) Upon filing with the Department of an applicable amended HMO contract with an IDS, the Department requests that the HMO submit a written report in a form which will be available from the Department.

(c) If no quarterly financial statement is required by the Department, the Department requests that the applicable amended contract, together with the written report, be filed within 45 days of the effective date of the amendment.

(d) Amended contract filings may be submitted with additional information that may be appropriate for the Department's review.

§ 301.314. Department review.

(a) The Department may review the HMO materials filed, to examine the transference of risk and other matters that may affect the financial condition of the HMO.

(b) In evaluating the financial condition of an HMO, the Department will ascertain whether one or more of the following are present in an IDS contract:

- (1) An appropriate provision similar to the hold harmless provision described in § 301.122 (relating to hold harmless), prohibiting the IDS and participating providers from billing HMO members.
- (2) A provision for the maintenance of books, accounts and records by the IDS to assure that transactions, including the risk transfer, are clearly, accurately and completely disclosed.

(3) Appropriate terms permitting the HMO to assure itself of the financial viability and condition of the IDS throughout the term of the contract. These terms might include one or more of the following:

(i) A provision authorizing the HMO to access the IDS's books, accounts and records upon terms and conditions as the HMO and the IDS may agree.

(ii) A provision requiring that the IDS secure an audited financial statement on at least an annual basis and that the HMO receive the audited statement on an annual basis and interim unaudited financial statements from the IDS on a regular and ongoing basis.

(iii) A provision authorizing the HMO to receive information regarding the IDS's reserves so that the HMO may adequately evaluate its reserves.

(iv) A provision for the IDS to post a letter of credit or other acceptable financial security, in a reasonable amount as agreed upon between the HMO and IDS.

(v) A provision establishing a withholding of the fee in a reasonable amount as agreed upon between the HMO and IDS and which may be returned to the IDS under the terms of the contract.

(vi) A provision for the IDS to carry general liability insurance and for participating providers to carry professional liability insurance in an amount and from a carrier mutually acceptable to the HMO and the IDS.

(vii) A provision for the IDS to secure a surety bond to cover the IDS's performance under the contract.

(viii) A provision for the IDS to secure excess of loss insurance in an amount and from a carrier mutually acceptable to the HMO and the IDS.

(4) A provision prohibiting the assignment of any rights or obligations under the contract in the absence of the consent of the HMO.

(5) A provision granting the HMO the right to be advised of, and the right to object to, any subcontractor of the IDS with respect to services required to be performed by the IDS under the contract with the HMO.

(6) Appropriate provisions for the termination of the contract, including consideration of whether the HMO has the right to immediately terminate the contract upon a valid order issued by the Commissioner or other lawful authority.

(7) A provision setting forth the circumstances under which the HMO may institute an appropriate financial monitoring plan of the IDS.

(8) A provision requiring that the IDS carry appropriate insurance coverage, such as fidelity bonds covering IDS employees who handle HMO funds and workers' compensation insurance.

- (9) A provision requiring that the IDS timely advise the HMO of relevant matters that may have a material effect on the IDS's ability to perform under the contract, including, for example, the following:
- (i) Whether the IDS or a participating provider is subject to an administrative order, cease and desist order, fine or license suspension.
 - (ii) Whether legal action has been taken which may have a material effect on the IDS's financial condition or the IDS's ability to perform under the contract.
- (c) The Department may seek additional information if one or more of the following exist:
- (1) A contract by which 50% or more of the HMO's annual aggregate premium is transferred to a single IDS.
 - (2) Multiple contracts by which 75% or more of the HMO's annual aggregate premium is transferred to one or more IDSs.
 - (3) A contract with an IDS that has control of the HMO. The Department presumes that control exists if an individual or entity, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of any other entity.
 - (4) A contract by which the claims processing, claims payment or claims adjudication functions are transferred to the IDS.
 - (5) A contract by which managerial control of the HMO's information system is transferred to the IDS.
 - (6) A contract when the HMO employs an individual who is also employed by the IDS.
 - (7) A contract when there is overlap between the officers or directors of the IDS and the HMO.
 - (8) A contract that contains a provision which might be construed as impeding or limiting the Department's authority to examine the books, accounts and records of the HMO and other persons under section 903(b) and (c) of The Insurance Department Act of 1921 (40 P. S. § 323.3(b) and (c)).

DEPARTMENT EXAMINATIONS

§ 301.321. Department examinations of HMOs.

- (a) The Department is authorized to conduct financial examinations of HMOs under section 901 of The Insurance Department Act of 1921 (40 P. S. § 323.1).
- (b) In its periodic financial examinations and other financial analyses of HMOs, the Department will continue to hold HMOs ultimately responsible for the liabilities arising under its subscriber agreements, regardless of whether the HMO has elected to contract with one or more IDSs to perform or arrange for the performance of services to HMO members.

(c) HMOs that contract with IDSs shall ensure that the HMOs remain able to meet their statutory financial reporting requirements, and otherwise comply with Department requests for information under section 11 of the act (40 P. S. § 1561) and section 903(a) of The Insurance Department Act of 1921 (40 P. S. § 323.1(a)).

Subchapter J. [Reserved]

Source

The provisions of this Subchapter J adopted October 2, 1998, effective January 1, 1999, 28 Pa.B. 5019; reserved March 10, 2000, effective March 11, 2000, 30 Pa.B. 1453. Immediately preceding text appears at serial pages (249129) to (249137).

§§ 301.401—301.403. [Reserved].

§§ 301.411—301.416. [Reserved].

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