Basis Statement and Summary of Comments
Rule Chapter 191 -“Health Maintenance Organizations”
Repeal of Rule Chapter 750 “Standardized Health Plans”

A. Summary of Amendments

Pursuant to the June 7, 2016, Notice of Rulemaking, Superintendent of Insurance Eric Cioppa held a public hearing on July 7, 2016 at the Department of Professional and Financial Regulation building, 76 Northern Avenue, Gardiner, Maine. The public comment period was held open until Friday July 22, 2016 at 4:30 p.m. The federal Affordable Care Act (ACA) and P.L. 2011 c. 90 rendered substantial portions of Rule Chapter 750 obsolete. The purposes of the amendments are to repeal the obsolete standards of Rule Chapter 750 and to incorporate the remaining relevant standards into the current Rule Chapter 191 in a manner consistent with P.L. 2011 c. 90 and the ACA. The proposals also update Rule Chapter 191 as to financial requirements for HMOs.

The Rule Chapter 191 amendments and the repeal of Chapter 750 were provisionally adopted by Superintendent Cioppa on November 18, 2016. Review of the provisionally adopted rulemaking was completed by the Office of Attorney General on December 16, 2016 and the provisionally adopted rulemaking was filed with the Office of the Secretary of State on December 19, 2016.

Through LD 556, the 128th Maine Legislature conducted its’ review of this major substantive rulemaking. The Legislature authorized final adoption of the rulemaking through Resolve 8 which became law without the Governor’s signature on April 30, 2017.

These amendments are adopted in accordance with 24-A §§212, 4203-A(1), 4218, 4222-A, and 4309.

B. The following person testified at the hearing:

Kristine M. Ossenfort, Esq.
Anthem Blue Cross and Blue Shield (Anthem)

C. The following persons submitted written comments on or before July 22, 2016:

Kristine M. Ossenfort, Esq.
Anthem

Katrina W. Clearwater, Esq.
Consumers for Affordable Health Care (CAHC)

D. Repeal of Rule 750

The only comment received on Rule 750 was from Anthem, which supports the repeal. Accordingly, Rule 750 is repealed as proposed.
E. Explanation of amendments to Rule 191 and summary of comments with Bureau of Insurance responses

1. General Comments:

Comment: CAHC stated that HMOs provide financial incentives to steer consumers to particular providers, and that consumers are at risk for misunderstanding their coverage and the network that is available to them at a lower rate.

CAHC stated that because of the potential for consumer confusion, the Superintendent must ensure that HMOs provide adequate communications to their members about coverage and the importance of using the HMOs’ in-network provider list. Ideally, HMOs would also adequately communicate to their members how best to use their HMO coverage.

CAHC further stated that a large part of the consumer confusion is the fact that provider directories are inaccurate. CAHC noted that it has worked with many consumers who have had coverage for services denied because the provider was out of network even though the consumer proactively sought assurances that the provider was in network. CAHC stated that the ACA and its implementing regulations added certain consumer protections regarding provider directories and that one of the requirements is that plans offered through the Federally Facilitated Marketplace must update their directories at least monthly. CAHC noted that they don’t know if plans are complying with that requirement. CAHC gave examples of some of the consumers they have helped who had provider directory issues.

CAHC requested that the Bureau include in the final rule requirements and clarification about the expectations of the accuracy of provider directories, how plans can meet those requirements, the consequences for failing to meet those requirements, and carrier liability when a covered member seeks assurances from the provider directory or from customer service that the provider is in-network and relies on those assurances by receiving the care. CAHC suggested that the state require plans to actively contact providers who are listed as in network who have not submitted claims within the past 6 months to determine whether the providers still intend to participate in the network. If providers don’t respond within 30 days, the plans should attempt to contact them again and then, in another 30 days if there is no response, the plan should remove them from the directory. CAHC also suggested that plans should hold consumers harmless for relying on inaccurate provider lists when receiving care.

CAHC also suggested that plans be required to conduct directory audits at least twice per year to assess the accuracy of the directory and to correct any discrepancies found.

Bureau Response: The issues raised by CAHC are common to all network plans and do not warrant different requirements for HMOs than for other types of health carriers that issue network plans. Therefore, they are appropriately addressed in Rule 850 rather than in this rule. The Bureau will consider the issues raised and determine whether they are better addressed by new rulemaking or by enforcement of existing requirements.

2. Section 3
Comment: The Proposed Amendments grant the Superintendent the authority to “waive certain requirements for HMOs with limited authority (for example an HMO licensed to offer only Medicare Advantage plans).” CAHC objects to this change, and alternatively, requests clarification of which additional types of HMOs might be eligible for this exception, apart from the Medicare Advantage example specified in the proposed language of the rule. CAHC also wants the Superintendent to provide a list of all the circumstances under which such an exception may be made and explain why such an exception would be made in those circumstances.

Bureau Response: The rule has been amended to specify that the phrase “HMOs with limited authority” refers to those HMOs that are exempt under 24-A M.R.S. § 4202-A(10-A) from providing the full range of basic health services. Medicare Advantage plans are a familiar and illustrative example. The rule cannot predict in advance what precise situations would be eligible for waiver, but a standard has been added to explain the appropriate grounds for waiver. As amended, the first paragraph of Section 3 reads as follows:

This rule regulation shall apply to all health maintenance organizations (HMOs) as defined by Title 24-A M.R.S.A. M.R.S. § 4202-A(10), except that the Superintendent may waive or modify certain requirements for HMOs with granted limited authority under 24 A M.R.S. § 4202-A(10)(A) (for example, an HMO licensed to offer only Medicare Advantage plans), if the Superintendent determines that those requirements were intended to apply only to full-service HMOs.

Comment: Anthem commented at the hearing and in written comments that with respect to the language that begins, “All group policies and certificate and individual contracts written, issued or renewed in this state on or after 6 months from the effective date of this rule shall conform with Section 9 of this rule,” that the 2017 individual and small group plans have already been filed with the Bureau and that certain plans in all likelihood will have been certified as Qualified Health Plans before finalization of the amendments to Rule 191. Anthem suggested that the requirements of section 9 be effective on a date certain and proposed Jan 1, 2018, as the date.

Bureau Response: We agree with the comment. The paragraph is changed to read:

All group policies and certificate certificates and individual contracts written, issued, or renewed in this State on or after 6 months from the effective date of this rule January 1, 2018 shall conform with Section 9 of this rule. For purposes of this rule, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract or evidence of coverage.

3. Paragraphs 6(E)(3–4)
Comment: CAHC commented that the proposed rule eliminates paragraphs 3 and 4, which provided certain circumstances under which HMO applicants would be required to provide the parent company’s annual statement. They stated that it is not clear why this requirement has been removed and requested that the Bureau clarify why this is necessary or reconsider removal of these provisions.
Bureau Response: These provisions were proposed for repeal because the financial statements of parent and affiliated insurers are now readily available through the NAIC. However, we agree that in order to access this information, the provisions need to be replaced rather than repealed outright. Therefore, a new paragraph 3 has been adopted, to read as follows:

3) Applicants with parent companies not licensed by the Superintendent must provide copies of the parent’s annual statement for the year prior to the date of the application.

4) Applicants with licensed or unlicensed parent companies that control other affiliated insurers that individually represent 30% or more of the parent’s asset base, must provide copies of the affiliated insurer’s annual statement/s for the year prior to the date of application.

3) The applicant shall provide its NAIC group code. If the applicant is not affiliated with an NAIC-designated insurance group, the applicant shall provide financial information satisfactory to the Superintendent relating to its parent company or other controlling person and its affiliates.

4. Paragraph 7(B)(4)
Comment: Anthem commented at the hearing and in written comments that the proposed paragraph 7(B)(4) requires that an HMO maintain a minimum surplus equal to 8% of annual health expenditures, but it is silent on the expenditures by whom. Anthem noted that it presumes that that the rule means the HMO’s expenditures, but assert that it is not clear. It suggested additional language to clarify what the 8% refers to.

Bureau Response: The clarification requested by Anthem has been made, along with similar clarifications to paragraphs (2) and (3), consistent with the underlying statutory language at 24-A M.R.S. §§ 4204-A(2)(C) & (D). As amended, paragraphs (2) through (4) read as follows:

2) Two percent (2%) of the first $150 million of annual premium revenues as reported in the HMO’s most recent annual financial statement on the first $150 million of premium and one percent (1%) of the annual premium in excess of $150 million;

3) An amount equal to the sum of three months’ uncovered health care expenditures as reported in the HMO’s most recent annual statement;

4) An amount equal to eight percent (8%) of the HMO’s annual health expenditures, except those paid on a capitated basis, as reported on the HMO’s most recent annual financial statement; or

5. Paragraph 9(A)(8)
Comment: CAHC commented that the Superintendent proposed removal of the paragraph that requires HMOs to include a statement in the Evidences of Coverage (EOC) that informs consumers of the privacy protections afforded them by 24-A M.R.S. § 4224. They noted that it is unclear why that has been removed. CAHC stressed the importance of ensuring that
consumers understand their privacy protections under federal and state laws. CAHC requested that the Superintendent leave this provision intact in the rule.

**Bureau Response:** Section 4224, enacted in 1991, is no longer the principal source of privacy protection for HMO enrollees. All health insurance carriers, including HMOs, now have both substantive privacy obligations and detailed notice requirements under HIPAA, the Maine Insurance and Privacy Protection Act, and other confidentiality laws, and it is therefore no longer necessary to impose different requirements on HMOs in this area.

6. **Paragraph 9(A)(9)**

*Comment:* CAHC commented that because of the confusing nature of HMO coverage, the Superintendent should include a requirement that the Explanation of Coverage (EOC) list in addition to the Bureau’s information (and consistent with Rule 850), the contact information for the State’s Consumer Assistance or Ombudsman Program, which is currently operated by CAHC.

*Bureau Response:* The Bureau finds it reasonable to require this information. Section 9(A)(9) is amended to read:

9) **Detailed information** about the availability of assistance regarding coverage, complaints, and appeals, including explanations of: on how to file a complaint or appeal, and a statement of the enrollee’s right to contact the Superintendent of Insurance for assistance at any time. The statement shall include the Superintendent’s telephone number and address. The notice shall contain a telephone number and address for the program.

   a) How to file a complaint or appeal, and a statement of the enrollee’s right to contact the Superintendent of Insurance for assistance at any time. The statement shall include the Superintendent’s telephone number and address.

   b) How to obtain assistance from the Maine Consumer Assistance Program in order to understand the enrollee’s coverage or appeal rights. The statement shall include the Program’s telephone number and address.

7. **Paragraph 9(A)(12)**

*Comment:* CAHC commented that paragraph 12 as proposed states that the EOC must include “[a] description of the services covered and excluded under the contract,” and requested adding additional language relating to prescription drug coverage.

*Bureau Response:* We find the clarification reasonable, and we accept CAHC’s suggested language. Paragraph 9(A)(12) is amended to read:

12) **A description of the** medications and services covered and excluded under the contract, including a description of how a consumer may obtain a copy of the plan’s certificate of coverage and a copy of the complete formulary or a URL or URLs at which the most current certificate of coverage and prescription formulary may be accessed.
8. **Subsection 9(B)**
Comment: This provision of the rule requires that “[e]xplanations of coverage must clearly outline the conditions that must be met by enrollees and their eligible dependents to obtain and maintain coverage.” CAHC commented that because of section 1557 of the Affordable Care Act, its recent implementing regulations, and the Mental Health Parity and Addiction Equity Act, the Superintendent should add the following language:

> “Under no circumstances shall such eligibility requirements discriminate on the basis of race, color, national origin, sex, age or disability. Nor shall such eligibility requirements discriminate based on mental health or substance use disorder diagnoses.

A plan that provides coverage for Essential Health Benefits will also be considered discriminatory if its benefit design, or the implementation of its benefit design, discriminates based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.”

**Bureau Response:** CAHC appropriately observes that recent federal legislation and regulations have adopted several specific nondiscrimination requirements. However, the Bureau believes that the existing language of the rule, together with the clarifying language that has been added at CAHC’s request to Subsection 9(N) below, fully addresses HMOs’ obligations to comply with these requirements.

9. **Subsection 9(D)**
Comment: CAHC commented that some individuals who are eligible for Medicare Part A without premium are not always cognizant of the fact that they are prohibited from enrolling in a Marketplace plan or that they are eligible for Medicare. CAHC suggests that the following language be added:

> “Coordination with Medicare is permitted under the same conditions and manner described in 24-A M.R.S. A. § 2844 and § 2723, applicable to non-HMO plans. Six months prior to an enrollee’s eligibility for Medicare, the plan shall notify the enrollee of such impending eligibility, and provide information about the assistance available through State Health Insurance Assistance Program (SHIP) counselors. If the enrollee purchased the plan on the Marketplace, the plan shall notify the enrollee of any prohibition to continue coverage under that plan should any prohibition apply.”

**Bureau Response:** We decline to accept the proposed changes. This issue is common to all health plans and does not warrant different requirements for HMOs than for other types of health plans. HMOs often also sell plans that coordinate with Medicare and provide the opportunity for enrollees to transition to a Medicare plan. We also note that although it may not be in a consumer’s best interest to continue their HMO plan when becoming eligible for Medicare, there is no prohibition on a consumer maintaining their plan if they choose.

10. **Subsection 9(F)**
Comment: CAHC commented that because the ACA and Rule 850 add rescissions of coverage to the list of adverse health care treatment decisions for which appeal rights are guaranteed, the
rule should require plans to include a statement that such rescission is appealable and refer to the section describing the enrollee’s appeal rights and process.

**Bureau Response:** Subsection 9(F) has been clarified as follows:

F. Cancellation or Termination

The group or individual contract shall contain the conditions upon which cancellation, rescission, or other termination may be effected by the HMO [consistent with 24-A M.R.S.A. § 4212(2)], the group contract holder, or the enrollee.

11. Paragraph 9(K)(3)

**Comment:** CAHC requested that the Superintendent amend the proposed language of the paragraph to allow the Superintendent to have the ability to make a determination that nonpayment of a premium is for good cause and that coverage must continue until such time as the enrollee is no longer incapacitated or the situation no longer prevents the enrollee from paying the premium, and a reasonable period has been allowed for the enrollee to cure the nonpayment. CAHC commented that the Superintendent should also require that the coverage be retroactive when he feels such retroactivity is warranted.

**Bureau Response:** The Bureau declines to accept the suggestion. An HMO accepts the contractual obligation to provide benefits in return for the enrollee’s contractual obligation to pay premiums. The law expressly provides that nonpayment is a valid ground for cancellation, and any exceptions should be made by the Legislature, not by the Superintendent.

**Comment:** Anthem commented that the language as written appears to be inconsistent with the provisions of 24-A M.R.S. §§ 2707-A and 2847-C, which govern third party notifications. Anthem noted that the way the proposed language reads, if the HMO has complied with any applicable third party notice requirement, coverage is automatically terminated at the end of the grace period. Anthem asserted that these sections do not establish a condition precedent to cancellation. Instead, they provide the subscriber with the ability to designate a third party to receive the same notice of cancellation as the subscriber and to establish a post-cancellation right of reinstatement. Anthem noted that the notices would be provided at the same time as the notice to the subscriber or group policyholder and do not affect the commencement of the grace period. Anthem suggests the following language instead:

3) If the premium is not paid during the grace period and the HMO has complied with any applicable third party notice requirements, coverage is automatically terminated at the end of the grace period, subject to any right of reinstatement pursuant to Title 24-A M.R.S.A. §§ 2707-A and 2847-C. For group contracts the HMO shall provide at least 10 days’ notice to the certificate holders prior to cancellation in a manner consistent with the requirements of 24-A M.R.S.A. § 2809-A(1-A). Following the effective date of such termination, the HMO shall send the contract holder written notice advising that coverage has been terminated.
Bureau Response: If a third party has been designated to receive notice, Bureau of Insurance Rule 580, § 5(C) requires notice to be given to the designated third party at least 10 days before the contract is cancelled. That makes notice a condition precedent to cancellation, which is the purpose of notice requirements. However, the general reference to compliance “with any applicable third party notice requirements” has been revised to clarify that the only requirement of Rule 580 that is a condition precedent is the requirement to give timely notice, and the language about the right to reinstatement has been added as requested. We do not agree with deletion of the requirement to provide at least 10 days’ notice to certificate holders in the same manner as the statute applicable to group health insurers. As amended, this paragraph reads as follows:

3) If the premium is not paid during the grace period and the HMO has complied with any applicable third party notice requirements given 10 days’ notice to the designated third party if one has been designated pursuant to Bureau of Insurance Rule 580, coverage is automatically terminated at the end of the grace period, subject to any right of reinstatement pursuant to 24-A M.R.S. §§ 2707-A or 2847-C. For group contracts the HMO shall provide at least 10 days’ notice to certificate holders prior to cancellation in a manner consistent with the requirements of 24-A M.R.S.A. M.R.S. § 2809-A(1-A). Following the effective date of such termination, the HMO shall send the contract holder written notice advising that coverage has been terminated.

12. Subsection 9(M)
Comment: CAHC commented that because section 1557 of the ACA and its implementing regulation prohibit discrimination on the basis of race, color, national origin, sex, age, or disability, it urges the Superintendent to include language in this subsection that also reflects that discrimination in benefit design and certain blanket exclusions shall not be allowed.

Bureau Response: As we stated in the response to the comment on Subsection 9 (B), the federal regulations are sufficient to ensure that the benefit design does not impermissibly discriminate against protected classes. We decline to adopt the suggestion.

13. Paragraph 9(M)(5)
Comment: CAHC commented that because section 1557 of the ACA and its implementing regulation prohibit discrimination on the basis of race, color, national origin, sex, age or disability, it urges the Superintendent to adopt language that makes it clear that the prohibition against discrimination in benefit design must also include prescription drug formulary design. Therefore, no plan shall design its formulary, including any tiering to include blanket exclusions of prescription drugs or otherwise, to discriminate on the basis of any of the protected classes.

Bureau Response: For the reasons stated previously, we decline to adopt the comment.

14. Paragraph 9(M)(6)
Comment: CAHC commented that while some emergency situations will dictate where an enrollee will be transported, in the event that an enrollee is able to express a preference for a particular facility with an established relationship with the providers or has family or other support nearby, and if that facility is capable of providing the necessary care the enrollee should
be transported to that facility (unless the distance is unreasonable or would jeopardize the enrollee’s health). CAHC notes that the transportation should be covered even if that facility is not the nearest one capable of providing care and they note that it is always in the enrollee’s best interest to seek treatment from a provider who is familiar with the enrollee’s care and to receive treatment at a facility accessible to family members or support. CAHC urges the Superintendent to amend the language to allow for transport to a facility of choice when the transport won’t jeopardize the enrollee’s health.

Bureau Response: When transportation to a particular facility is medically necessary, coverage is already required by Rule 850, § 7(B)(4). To the extent that it is a matter of consumer preference rather than medical necessity, the benefits need to be balanced with the costs, so this should be an option in the marketplace rather than a uniform requirement. Furthermore, it would be a mandated benefit that would be beyond the Superintendent’s statutory authority to impose by rulemaking.

15. Paragraph 9(M)(7)
Comment: CAHC commented that rather than limiting the coverage of home health care services to a written plan by a physician, CAHC urged the Superintendent to broaden the scope to include other health care providers. Mid-level practitioners have over time been increasing their scope of practice and have increasingly become the primary care provider of choice for many consumers. CAHC suggested that the Superintendent use more flexible language to allow for these types of changes in the future.

Bureau Response: The Bureau accepts the suggested language. Paragraph 9(M)(7) is amended to read:

Home health care by an accredited agency under a written plan by a physician, or other licensed provider such as a Nurse Practitioner or Physician Assistant, working within the provider’s scope of practice, for a minimum of 90 visits per calendar year.

16. Subsection 9(N)
Comment: CAHC commented that while the ACA allows for certain benefit exclusions, in light of section 1557 of the ACA and its implementing regulations, they suggest the following language:

“The plan may contain exclusions approved by the Superintendent that are not otherwise prohibited by state or federal law, rule or regulation. Unless otherwise directed by the Superintendent, HMO plans may contain exclusions similar to exclusions permitted in non-HMO plans that provide Essential Health Benefits in accordance with the Affordable Care Act as long as the basis for the exclusion is evidence-based and nondiscriminatory. Under no circumstances shall exclusions discriminate on the basis of race, color, national origin, sex, age or disability. Nor shall there be any categorical coverage exclusions based on gender, sex stereotyping, gender identity or related to gender transition.
Should a plan decide to exclude services from coverage entirely, the evidence upon which the plan relied to make the exclusion shall be made available to the Superintendent or the member or the prospective member within seven (7) days or such a request.”

Bureau Response: The Bureau agrees with the proposal to clarify that only those exclusions that are otherwise lawful are permitted. Accordingly, it is unnecessary to repeat that exclusions that would violate ACA § 1557 are unlawful. We believe that an additional requirement that each exclusion be justified through an evidentiary process requirement would be unduly burdensome for carriers. As revised, Subsection 9(N) reads as follows:

N. Exclusions.

The plan may contain exclusions approved by the Superintendent that are not otherwise prohibited by state or federal law, rule, or regulation. Unless otherwise directed by the Superintendent, HMO plans may contain exclusions similar to exclusions permitted in non-HMO plans that provide Essential Healthcare Benefits in accordance with the Affordable Care Act.

17. Subsection 9(O)
Comment: CAHC commented that even though this particular section was not amended, it is difficult for a consumer to read through a contract and formulate an opinion within 10 days after receiving it. CAHC asserts that a more reasonable time period for consumers would be 14 calendar days or 10 business days. CAHC also urges the Superintendent to require HMOs to provide a contract to a consumer within 14 days after the commencement of coverage, stating that it is not clear how long the HMO has to deliver the contract to the consumer. CAHC asks whether the consumer could be held responsible for the payment of services if it takes an HMO a significant amount of time to provide the contract and the consumer decides to return the contract after finally receiving it.

Bureau Response: The Bureau did not amend this portion of the rule and therefore it would be unfair to change it without receiving comment on the proposed language from other parties. The Bureau declines to adopt the suggestion. The 10-day “free look” period for HMO contracts is consistent with the statutory provisions that apply to life, health, and disability insurance policies under 24-A M.R.S. §§ 2515-A and 2717. If HMOs are delaying providing contracts to their enrollees, the Bureau will take measures to enforce their statutory obligations to provide evidence of coverage as required by 24-A M.R.S. § 4207.

18. Subsection 10(C)
Comment: CAHC commented that because inquiries to the HMO may involve coverage of care that a consumer needs but that the HMO is refusing to cover, they urge the Superintendent to consider amending the proposed language to require a response within 7 days after a consumer complaint rather than 14.

Bureau Response: When a consumer objects to an adverse health care treatment decision, the time frames for action by the carrier are governed by Bureau of Insurance Rule 850, and expedited appeals are available when immediate action is necessary. Therefore, it is not
necessary to make exceptions to the 14-day response period established for all licensees under 24-A M.R.S. § 220(2). It should be noted that Subsection 10(C) is not a new addition to the rule, but merely relocates existing language.

19. Request for new Subsection 10(D)
Comment: CAHC further urges the Superintendent to insert a new section requiring that HMOs respond within 7 days of a consumer’s or authorized representative’s request for information or documentation. CAHC noted that there have been many times in which they have experienced delays with carriers providing information and it has been detrimental to the consumer. CAHC gave one example of a consumer who had requested information multiple times only to have it provided on the eve of the appeal hearing. CAHC also noted that they have been several recent issues with carriers not providing information with respect to internal and external appeals.

Bureau Response: If such a provision is necessary, it would belong in Rule 850, not in this rule. The Bureau will consider whether the issues raised by CAHC are better addressed through rulemaking or through communication with carriers and enforcement of requirements that are already in place.