# **02 DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION**

**031 BUREAU OF INSURANCE**

**Chapter 840: private purchasing alliances**

**Table of Contents**

Section 1. Authority

Section 2. Purpose

Section 3. Scope

Section 4. Definitions

Section 5. Licensure

Section 6. Participating Carriers

Section 7. Risk Pools

Section 8. Marketing

Section 9. Additional Duties

Section 10. Additional Restrictions

Section 11. Examination

Section 12. Effective Date

**Section 1. Authority**

This Rule is adopted by the Superintendent pursuant to 24-A M.R.S.A. §§ 212, 1952-1957, and 2808-B(2)(F).

**Section 2. Purpose**

 The purpose of this Rule is to supplement Chapter 18-A of Title 24-A M.R.S.A. by establishing additional standards for private purchasing alliances.

**Section 3. Scope**

 This Rule applies to private purchasing alliances as defined by 24-A M.R.S.A. § 1951(2) and to carriers contracting with such alliances.

**Section 4. Definitions**

 A. "*Alliance*" means a private purchasing alliance as defined by 24-A M.R.S.A. § 1951(2).

B. "*Board*" means the Board of Directors of a private purchasing alliance.

C. "*Carrier*" has the same meaning as in 24-A M.R.S.A. § 1951(1).

D. "*Enrollee*" means an individual, employee, or dependent who is enrolled in a health benefit plan offered through the alliance by a participating carrier.

E. "*Individual*" means an individual not affiliated with a member employer.

F. "*Individual member*" means an individual who enrolls in a private purchasing alliance.

G. "*Member*" means an individual member or a member employer.

H. "*Late enrollee*" has the same meaning as in 24-A M.R.S.A. § 2808-B(1)(E).

I. "*Member employer*" means an employer that enrolls in a private purchasing alliance.

J. "*Participating carrier*" means a carrier that contracts with a private purchasing alliance to provide coverage to enrollees under a health benefit plan.

K. "*Small employer*" means an "eligible group" as defined by 24-A M.R.S.A. § 2808‑B(1)(D).

L. "*Superintendent*" means the Superintendent of Insurance.

**Section 5. Licensure**

A. An applicant for licensure as a private purchasing alliance, pursuant to 24-A M.R.S.A. § 1952, must file an application with the Superintendent, accompanied by an application fee of $400 and including the following information:

(1) A detailed, written business plan explaining how the applicant intends to meet the public policy objectives of reduced cost, increased access, and improved quality in the marketplace. Material changes in policy or operations of the business plan are subject to the prior approval of the Superintendent. The business plan shall include, but not be limited to, the following information:

(a) The specific steps planned to advance cost control and quality improvement, and to improve access to health insurance or health care services. The business plan shall demonstrate that the alliance will have the technical expertise and physical capacity to serve a significant population. There is a rebuttable presumption that ten percent of the population within the proposed service area is an appropriate threshold for measuring significance. The business plan shall demonstrate that the alliance will reduce cost, improve quality, and improve access to health insurance or health care services; and

(b) The scope of services to be offered in the proposed service area and the resources and expertise to be used to implement and administer those services. An alliance shall demonstrate the technical and physical capacity to serve a significant population over a wide territory, and to provide service quality throughout the entire alliance service area;

(2) The applicant's articles of incorporation, bylaws, and other formation and business operation documents. An alliance must demonstrate to the satisfaction of the Superintendent that its corporate governance makes it an appropriate and effective representative of the interests of the population to be served within the proposed service area. An alliance must demonstrate that it is more than a marketing or distribution channel for a single product or the products of a single carrier.

(3) A list of officers and directors of the applicant and the contract administrator, if one is employed, and personal biographical information or firm descriptions for each. The officers, directors and contract administrator shall not have a prior record of administrative, civil, or criminal violations within any financial service industry. The personal biographical information and firm descriptions shall demonstrate that those involved in the operation of the alliance have the expertise, experience, and character to effectively and professionally represent the population to be served in a fiduciary capacity;

(4) Evidence of adequate security and prudence in the accounting, deposit, collection, handling, and transfer of money. An alliance shall also demonstrate adequate financial controls;

(5) The population to which the alliance will be marketing;

(6) Enrollment procedures to be used by the alliance;

(7) Eligibility standards for membership in the alliance;

(8) The standards to be used by the alliance to classify members into one or more risk pools;

(9) The criteria to be used by the alliance to select participating carriers; and

(10) Disclosure of any preexisting oral or written agreements with carriers, employers, or others.

B. Grounds for Denial, Nonrenewal, Suspension, or Revocation of License. In addition to any other grounds specified by law, the following may constitute grounds for denial of an application or nonrenewal, suspension, or revocation of an existing license, following notice and an opportunity for hearing:

(1) Failure to comply with the provisions of this Rule or with Chapter 18-A of Title 24-A M.R.S.A.;

(2) Failure to comply with and carry out the alliance business plan approved by the Superintendent;

(3) Failure to have adequate operational/financial controls or failure to follow approved procedures;

(4) Failure to meet minimum standards in a financial or performance audit or examination;

(5) Failure to comply with a lawful order of the Superintendent;

(6) Committing an unfair or deceptive act or practice as defined in Chapter 23 of 24-A M.R.S.A.;

(7) Filing any necessary form with the Superintendent that contains fraudulent information or omission; or

(8) Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand funds that have been entrusted to the alliance in its fiduciary capacity.

C. Renewal and Reporting Requirements

(1) The alliance shall submit quarterly financial statements and annual reports on forms approved by the Superintendent. The financial statements and annual reports shall be designed to verify the operation of the alliance in a sound financial fashion, to ensure the alliance is not a risk-bearing entity, to verify the existence of sound financial controls and money management, to reveal any mismanagement or misappropriation of funds either through neglect or malfeasance, and to show whether the alliance membership includes a representative demographic sample of the eligible population;

(a) The annual report shall be submitted by March 1 for the preceding calendar year and shall be accompanied by an audited financial statement and a license renewal fee of $100. The report shall include:

(i) An accounting of all revenues received by the alliance;

(ii) Internal and independent audits;

(iii) Enrollment data showing, by carrier, the number of individuals and, for each employer risk pool, the number of employers and the number of employees;

(iv) Enrollment data by age and gender;

(v) Results of enrollee satisfaction surveys if any;

(vi) Reports of any legal actions taken by or against the alliance.

(vii) The progress achieved in assuring affordable health care coverage to individual members and employees of member employers; and

(viii) The need, if any, for financial incentives or other mechanisms to increase participation in the alliance.

(b) The quarterly financial statements shall be submitted within 60 days of the end of each calendar quarter.

(2) Material changes in the business plan are subject to approval by the Superintendent before implementation by the alliance.

**Section 6. Participating Carriers**

A. To be eligible as a participating carrier, a carrier must demonstrate the following operating characteristics to the alliance board's satisfaction:

(1) That the carrier is licensed and in good standing with the Superintendent. The board shall request certification from the Superintendent that all participating carriers are licensed carriers and that all carriers to be offered to small employers have filed forms and rates pursuant to 24-A M.R.S.A. § 2808-B;

(2) The ability to administer health benefit plans, to provide adequate service, and to comply with all contractual requirements of the alliance;

(3) The ability to provide enrollees with reasonable access to covered services;

(4) The ability to provide coverage for enrollees in any service area in which the carrier plans to participate through the alliance;

(5) The ability to arrange and pay for the appropriate quality, level, and type of health care services;

(6) The ability to provide data required by the board, including information on enrollee satisfaction based on standard surveys and to meet reasonable satisfaction measures as the board may establish;

(7) Strong financial condition;

(8) Adequate administrative management;

(9) A procedure to address enrollee grievances and appeals;

(10) The ability to achieve satisfactory enrollment levels within the service area in which the carrier is licensed; and

(11) All other criteria established by the board.

B. In evaluating which carriers may participate in the alliance, the board shall consider:

(1) Minimum geographic service and participation requirements, maximum levels for premium rates, and standards for determining whether a carrier operates efficiently;

(2) Pricing and the competitiveness of each bid from a carrier; and

(3) The effect of contracting with additional carriers on the administrative costs of the alliance and its members, and the competitiveness of the premiums that will be paid to participating carriers.

C. Contracts between the board and participating carriers shall specify how all premiums will be transmitted, grace periods for payments, and penalties for late payments.

D. Nothing in this Rule prohibits a participating carrier from contracting with particular health care providers or types, classes, or categories of health care providers, or from setting reimbursement methodology.

E. When filing rates with the Superintendent for use with alliance products offered to individuals or small employers, the carrier shall include a comparison of the alliance rates to the carrier's rates for the same or similar product offered outside the alliance. The filing must demonstrate that all rate differences are attributable to differences in administrative costs, marketing costs, profit margins, economies of scale, product design, or other factors unrelated to health status or perceived health risk. Differences in product design may include differences in benefits, provider networks, provider contracts, or case management provisions.

**Section 7. Risk Pools**

A. If the alliance is designed to include individuals unaffiliated with an employer, all such individuals shall constitute a separate risk pool. Participating carriers may vary rates within this risk class only as would be permitted for an individual health plan subject to 24-A M.R.S.A. § 2736-C. A carrier may offer coverage to individuals through the alliance even if the carrier does not offer the same coverage, or any coverage, through individual health plans outside the alliance.

B. If the alliance is to include small employers, all such employers shall constitute a separate risk pool. Participating carriers may vary rates within this risk class only as permitted pursuant to 24-A M.R.S.A. § 2808-B.

C. The alliance and any participating carrier may negotiate rates for the individual or small employer risk pool which are less than the carrier's otherwise applicable individual or small group rates, but only if the reductions reflect savings derived from administrative costs, marketing costs, profit margins, economies of scale, or other factors unrelated to the pool's health status or perceived health risk. Reductions may not be based on any of the rating factors expressly prohibited or limited by 24-A M.R.S.A. §§ 2736-C(2) and 2808-B(2).

**Section 8. Marketing**

A. Any marketing, advertisement, or educational material for health benefit plans sold through the alliance shall be approved by the board prior to its use.

B. A participating carrier, agent, broker, or contractor of a participating carrier, or an independent insurance agent, broker, or contractor may not engage, directly or indirectly, in an activity or marketing practice that would encourage member individuals, small employers, or eligible enrollees to:

(1) Refrain from enrolling in a health benefit plan offered through an alliance because of their health status or claims experience;

(2) Seek coverage from other participating carriers because of their health status or claims experience; or

(3) Enroll or fail to enroll in the alliance because of their health status or claims experience.

**Section 9. Additional Duties**

In addition to the duties set forth in 24-A M.R.S.A. § 1954, an alliance shall:

A. Provide that each eligible employee of any member employer is permitted to enroll in any health benefit plan offered to the applicable risk pool by any participating carrier that provides coverage where he or she works or lives;

B. Ensure that contracts with member individuals or employers meet the following requirements:

(1) For administrative purposes, the alliance will be the policyholder or contract holder of the health benefit plan on behalf of member individuals and employers, their eligible employees, and dependents;

(2) The contracts shall provide that the participating carrier will issue a certificate of coverage specifying the essential features of the health benefit plan's coverage to each individual member and eligible employee; and

(3) The contract shall provide that health benefit plans offered by the employer must be procured through the alliance.

C. Receive, review, and act, as appropriate, on grievances by member individuals, employers, or enrollees;

D. Establish administrative and accounting procedures for operating the alliance and for providing services to member individuals, employers, and employee enrollees;

E. Establish procedures for billing and collection of premiums from members (including any share of the premium paid by employee enrollees);

F. Establish procedures for annual or rolling open enrollment periods during which:

(1) Individuals or employees enrolled in health benefit plans through the alliance may elect to enroll in any health benefit plan that is available to the applicable risk pool through the alliance and that provides health coverage where they live or, if coverage is through a participating employer, where they work; and

(2) Late enrollees may elect to enroll in any health benefit plan that is available through the alliance and that provides health coverage where they live or, if coverage is through a participating employer, where they work;

G. Provide that in the event a member terminates coverage purchased through the alliance, the former member shall be ineligible to purchase a health benefit plan through the alliance for a period of twelve months; and

H. Treat all members within a risk pool equally with regard to membership fees, administrative fees, and benefits of membership.

**Section 10. Additional Restrictions**

In addition to the restrictions set forth in 24-A M.R.S.A. § 1955, an alliance shall not:

A. Commit an act constituting a rebate prohibited pursuant to 24-A M.R.S.A. § 2160;

B. Charge a fee for activities unrelated to health care or otherwise not directly related to the operation of the alliance;

C. As a condition of membership, require an individual or an employer to subscribe to limited benefit health insurance or non-health care related products or services;

D. Engage in any competitive act or practice that results in the selection of member individuals based on any of the risk factors, other than geographic area, prohibited or limited by 24-A M.R.S.A. § 2736-C(2);

E. Engage in any competitive act or practice that results in the selection of member small employers and enrollees based on any of the risk factors, other than geographic area, prohibited or limited by 24-A M.R.S.A. § 2808-B(2); or

F. Require or take any action inconsistent or in conflict with applicable law.

**Section 11. Examination**

Financial and performance audits or examinations of the alliance shall be conducted on a regular basis by the Superintendent. Reasonable costs of examinations or audits are to be paid by the alliance. After notice and opportunity for hearing, and for good cause shown, the Superintendent may impose conditions on licensure, or continued licensure to remedy compliance or performance problems; for example, the removal and replacement of managerial, marketing staff, or third-party contractors.

**Section 12. Effective Date**

This Rule is effective June 4, 1997. The 2002-2003 amendments to this Rule are effective July 4, 2003.

STATUTORY AUTHORITY: 24-A M.R.S.A. §§ 212, 1952-1957, and 2808-B(2)(F)

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