MODEL REGULATION TO IMPLEMENT RULES REGARDING CONTRACTS AND SERVICES OF HEALTH MAINTENANCE ORGANIZATIONS

Table of Contents

PREAMBLE

In 1989 the NAIC adopted a significantly revised version of the Model HMO Act. In order to reflect those changes, the NAIC model HMO regulations have been revised to incorporate language that compliments the revised model act, and to delete provisions that are no longer supported by the model. The range of issues for which various states have regulations continue to exceed the regulatory requirements that are common to the majority of states. Further, the range of issues appears to exceed the range of topics specifically addressed in the NAIC model act. This is due, in part, to the rapid evolution of the HMO industry over the past several years coupled with the rapid shift to a more business-oriented environment.

Authorities created by statute vary substantially from state to state and even though it is likely that no single state currently addresses all of the topics presented in this regulation, it was the consensus of the committee that the purview of the model regulation be broad enough to address the entire range of topics that have been identified, rather than remaining silent on certain issues on the basis of uncertainty of jurisdiction in individual states. Because of the variation of authorities that exist, it is incumbent on individual states to ascertain the limits of that authority in the application of the model regulation. Each state will thus be required to limit application of the model regulation, or seek appropriate statutory authority where authority does not appear to presently exist.

Section 1. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite section of law enacting the state Health Maintenance Organization Act and any other appropriate sections of law regarding the authority to issue or promulgate rules and regulations vested in the commissioner and the Commissioner of Health where applicable].

Section 2. Purpose

The purpose of this regulation is to implement [cite section of law which sets forth the state Health Maintenance Organization Act] to assure the availability, accessibility and quality of services provided by health maintenance organizations (HMOs) and to provide reasonable standards for terms and provisions contained in HMO group and individual contracts and evidences of coverage.

Section 3. Applicability and Scope

This regulation shall apply to all HMOs that are required to obtain a certificate of authority in this state. In the event of conflict between the provisions of this regulation and the provisions of any other regulation issued by the commissioner, the provisions of this regulation shall be controlling as to HMOs.

Section 4. Effective Date

A. This regulation shall be effective on [insert date].

B. All group and individual contracts written or issued on or after [use a date six months from the effective date of these regulations] shall conform with the provisions of these regulations. [Give specific citations to clarify that this includes the entire set of regulations and not just this section.]

C. No group or individual contract or evidence of coverage shall be reissued, renewed, amended or extended in this state on or after [date in Subsection A above] unless it complies with this regulation. A group or individual contract or evidence of coverage approved before [date from Subsection A] shall be deemed to be reissued, renewed, amended or extended on the date the health maintenance organization changes the terms of the group or individual contract or evidence of coverage or adjusts the premiums charged. A group or individual contract or evidence of coverage shall comply with this regulation when amended but in no event later than twelve (12) months after the effective date of this regulation.

Section 5. Definitions

A group or individual contract or evidence of coverage delivered or issued for delivery to any person in this state by an HMO required to obtain a certificate of authority in this state shall contain definitions respecting the matters set forth below. The definitions shall comply with the requirements of this section. Definitions other than those set forth in this regulation may be used as appropriate providing that they do not contradict these requirements. All definitions used in the group or individual contract and evidence of coverage shall be in alphabetical order. As used in this regulation and as used in the group or individual contract and evidence of coverage:

A. “Basic health care services” means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.

B. “Copayment” means the amount an enrollee must pay in order to receive a specific service that is not fully prepaid.

C. “Deductible” means the amount an enrollee is responsible to pay out-of-pocket before the HMO begins to pay the costs or provide the services associated with treatment.

D. “Eligible dependent” means a member of a subscriber’s family who meets the eligibility requirements set forth in Section 6B of this regulation.

E. “Emergency care services” means:

(1) Within the service area: covered health care services rendered by affiliated or non-affiliated providers under unforeseen conditions that require immediate medical attention. Emergency care services within the service area shall include covered health care services from non-affiliated providers only when delay in receiving care from the HMO could reasonably be expected to cause severe jeopardy to the enrollee's condition.

(2) Outside the service area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the HMO's service area.

F. "Enrollee" means an individual who is covered by an HMO.

G. "Evidence of coverage" means a statement of the essential features and services of the HMO coverage that is given to the subscriber by the HMO or by the group contract holder.

H. "Extension of benefits" means the continuation of coverage of a particular benefit provided under a group or individual contract following termination with respect to an enrollee who is totally disabled on the date of termination.

I. "Grievance" means a written complaint submitted in accordance with the HMO's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the HMO relative to the enrollee.

J. "Group contract" means a contract for health care services which by its terms limits eligibility to enrollees of a specified group. The group contract may include coverage for dependents.

K. "Group contract holder" means the person to which a group contract has been issued.

L. "Health maintenance organization" or "HMO" means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments and deductibles.

M. "Hospital" means a duly licensed institution that provides general and specialized inpatient medical care. The term "hospital" shall not include a convalescent facility, nursing home, or an institution or part of an institution that is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged.

N. "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include coverage for dependents of the subscriber.

O. "Medical necessity" or "medically necessary" means appropriate and necessary services as determined by a provider affiliated with the HMO that are rendered to an enrollee 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 are not provided only as a convenience. This does not preclude the HMO from establishing standards by which providers make their decisions as to what is medically necessary or from penalizing providers for failure to meet these standards.In the case of emergency medical services, the HMO has the right to make the final determination of whether services should be covered.

Drafting Note: This definition gives the provider the authority to determine what is medically necessary.

P. "Non-basic health care services" means health care services, other than basic health care services, that may be provided in the absence of basic health care services.

Q. "Out-of-area services" means the health care services that an HMO covers when its enrollees are outside of the service area.

R. "Participating provider" means a provider as defined in Subsection U below who, under an express or implied contract with the HMO or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the HMO.

S. "Physician" means a licensed doctor of medicine or osteopathy practicing within the scope of the license.

T. "Primary care physician" means a physician who supervises, coordinates, and provides initial and basic care to enrollees, and who initiates their referral for specialist care and maintains continuity of patient care.

U. "Provider" means a physician, hospital or other person licensed or otherwise authorized to furnish health care services.

V. "Replacement coverage" means the benefits provided by a succeeding carrier.

W. "Service area" means the geographical area as approved by the commissioner within which the HMO provides or arranges for health care services that are available and accessible to enrollees.

X. "Skilled nursing facility" means a facility that is operated pursuant to law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed physician.

Y. "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

Z. "Supplemental health care services" means any health care services that are provided in addition to basic health care services.

Section 6. Requirements for Contracts and Evidence of Coverage

Each subscriber shall be entitled to receive an individual contract or evidence of coverage in a form that has been approved by the commissioner. Each group contract holder shall be entitled to receive a group contract as approved by the commissioner. Group contracts, individual contracts and evidences of coverage shall be delivered or issued for delivery to subscribers or group contract holders within a reasonable time after enrollment, but not more than fifteen (15) days from the later of the effective date of coverage or the date on which the HMO is notified of enrollment.

A. Health Maintenance Organization Information. The group or individual contract and evidence of coverage shall contain the name, address and telephone number of the HMO, and where and in what manner information is available as to how services may be obtained. A telephone number within the service area for calls, without charge to members, to the health maintenance organization's administrative office shall be made available and disseminated to enrollees to adequately provide telephone access for enrollee services, problems or questions. An HMO shall provide a method by which the enrollee may contact the HMO, at no cost to the enrollee. This may be done through the use of toll-free or collect telephone calls, etc. The enrollee shall be informed of the method by notice in the handbook, newsletter or flyer. The group or individual contract or evidence of coverage may indicate the manner in which the number will be disseminated rather than list the number itself.

B. Eligibility Requirements

(1) The group or individual contract and evidence of coverage shall contain eligibility requirements indicating the conditions that shall be met to enroll as a subscriber or eligible dependent, the limiting age for subscribers and eligible dependents including the effects of Medicare eligibility, and a clear statement regarding coverage of newborn children.

(2) A group or individual contract or evidence of coverage shall not contain a provision excluding or limiting coverage for a newborn child. Medically diagnosed congenital defects and birth abnormalities shall be treated the same as any other illness or injury for which coverage is provided. The group or individual contract and evidence of coverage may require that notification of birth of a newborn child and payment of any required premium shall be furnished to the HMO within thirty-one (31) days after the date of birth in order to have coverage continue beyond the thirty-one-day period. The HMO is entitled to premium for the first thirty-one (31) days of coverage, unless the coverage is rejected by the subscriber prior to the birth of the child.

Drafting Note: Although state laws vary as to coverage for eligible dependents and newborns, many states require coverage; therefore suggested provisions have been included. If a state does not have authority in these areas, only the first paragraph should be included when adopting this regulation.

(3) The definition of an eligible dependent shall include:

(a) The spouse of the subscriber; and

(b) An unmarried dependent child of the subscriber who:

(i) Has not reached age [insert age]; or

(ii) Has reached [insert age] through [insert age] who is attending a recognized college or university, trade or secondary school on a full-time basis; or

(iii) Has reached age [insert age] but who is incapable of self-support because of mental retardation, mental illness or physical incapacity which began before the child reached age [insert age], and who is chiefly dependent upon the subscriber for support and maintenance.

Drafting Note: Paragraph (3) is an optional provision that may be used to define eligible dependents, if the state has that authority.

(4) The definition of a dependent child of a subscriber shall include a child who:

(a) Is related to the subscriber as a natural child, a legally adopted child or a stepchild; or

(b) Resides in the subscriber's household and who qualifies as a dependent of the subscriber or the subscriber's spouse under the U.S. Internal Revenue Code and the federal tax regulations; or

(c) Is eligible by virtue of a court order making the subscriber responsible for health care services for the dependent child.

Drafting Note: Paragraph (4) is an optional provision that may be used to define the dependent child of a subscriber.

C. Benefits and Services within the Service Area. The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available within the service area.

D. Emergency Care Benefits and Services. The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available for emergencies twenty-four (24) hours a day, seven (7) days a week, including disclosure of any restrictions on emergency care services. No group or individual contract or evidence of coverage shall limit the coverage of emergency services within the service area to affiliated providers only.

E. Out of Area Benefits and Services. The group or individual contract and evidence of coverage shall contain a specific description of benefits and services available out of the service area.

F. Copayments and Deductibles. The group or individual contract and evidence of coverage shall contain a description of any copayments or deductibles that must be paid by enrollees.

G. Limitations and Exclusions. The group or individual contract and evidence of coverage shall contain a description of any limitations or exclusions on the services, kind of services, benefits or kind of benefits including any limitations or exclusions due to preexisting conditions, waiting periods or an enrollee's refusal of treatment.

H. Enrollee Termination

(1) An HMO shall not cancel or terminate coverage of services provided an enrollee under an HMO group or individual contract except for one or more of the following reasons:

(a) Failure to pay the amounts due under the group or individual contract;

(b) Fraud or material misrepresentation in enrollment or in the use of services or facilities;

(c) Material violation of the terms of the group or individual contract;

(d) Failure to meet the eligibility requirements under a group contract;

(e) Termination of the group contract under which the enrollee was covered;

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

(i) It is shown that the HMO has, in good faith, provided the enrollee with the opportunity to select an alternative primary care physician;

(ii) The enrollee has repeatedly refused to follow the plan of treatment ordered by the physician; and

(iii) The enrollee is notified in writing at least thirty (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; or

(g) Other good cause agreed upon in the group or individual contract and approved by the commissioner. However, coverage shall not be cancelled or terminated on the basis of the status of the enrollee's health or because the enrollee has exercised his or her rights under the HMO's grievance procedure by registering a grievance against the HMO.

(2) An HMO shall not cancel or terminate an enrollee's coverage for services provided under an HMO group or individual contract without giving the enrollee at least fifteen (15) days written notice of termination. Notice will be considered given on the date of mailing or, if not mailed, on the date of delivery. This notice shall include the reason for termination. If termination is due to nonpayment of premium, the grace period required in Section 6W of this regulation shall apply. Advance notice of termination shall not be required to be given for termination due to non-payment of premium.

(3) (a) An HMO shall not terminate coverage of a dependent child upon attainment of the limiting age if the child is and continues to be both:

(i) Incapable of self support because of mental retardation, mental illness or physical incapacity, and

(ii) Chiefly dependent upon the subscriber for support and maintenance.

(b) Proof of incapacity and dependency shall be furnished to the HMO by the subscriber within thirty-one (31) days of the child's attainment of the limiting age and subsequently as reasonably required by the HMO.

I. Enrollee Reinstatement. If an HMO permits reinstatement of an enrollee's coverage, the group or individual contract and evidence of coverage shall include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the HMO and that the HMO is not obligated to reinstate any terminated coverage.

J. Claims Procedures. The group or individual contract and evidence of coverage shall contain procedures for filing claims that include:

(1) Any required notice to the HMO;

(2) If any claim forms are required, how, when and where to obtain and submit them;

(3) Any requirements for filing proper proofs of loss;

(4) Any time limit of payment of claims;

(5) Notice of any provisions for resolving disputed claims, including arbitration; and

(6) A statement of restrictions, if any, on assignment of sums payable to the enrollee by the HMO.

K. Enrollee Grievance Procedures and Arbitration. In compliance with Section 9D of this regulation, the group or individual contract and evidence of coverage shall contain a description of the HMO's method for resolving enrollee grievances, including procedures to be followed by the enrollee in the event any dispute arises under the contract, including any provisions for arbitration.

L. Continuation of Coverage. A group contract and evidence of coverage shall contain a provision that an enrollee who is an inpatient in a hospital or a skilled nursing facility on the date of discontinuance of the group contract shall be covered in accordance with the terms of the group contract until discharged from the hospital or skilled nursing facility. The enrollee may be charged the appropriate premium for coverage that was in effect prior to discontinuance of the group contract.

Drafting Note: Group contracts and evidences of coverage are required to contain a continuation of coverage provision to protect enrollees who are in the hospital or a skilled nursing facility when a contract is discontinued. Requirements concerning medically necessary care, copayments and deductible would still apply.

M. Conversion of Coverage

(1) (a) The group or individual contract and evidence of coverage shall contain a conversion provision that provides that each enrollee has the right to convert coverage to an individual HMO contract in the following circumstances:

(i) Upon termination of eligibility for coverage under a group or individual contract; or

(ii) Upon termination of the group contract.

(b) To obtain the conversion contract, an enrollee shall submit a written application and the applicable premium payment to the HMO within thirty-one (31) days after the date the enrollee's eligibility for coverage terminates.

(2) A conversion contract shall not be required to be made available if:

(a) The enrollee's termination of coverage occurred for any of the reasons listed in Subsection H(1)(a), (b), (c), (f) or (g);

(b) The enrollee is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act (Medicare);

(c) The enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under state or federal law;

(d) The enrollee is covered by or is eligible for similar hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group;

(e) The enrollee is covered for similar benefits by an individual policy or contract; or

(f) The enrollee has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(3) The conversion contract shall provide basic health care services to its enrollees as a minimum.

(4) The conversion contract shall begin coverage of the enrollee formerly covered under the group or individual contract on the date of termination from the group or individual contract.

(5) Coverage shall be provided without requiring evidence of insurability and shall not impose any preexisting condition limitations or exclusions as described in Section 7A other than those remaining unexpired under the contract from which conversion is exercised. Any probationary or waiting period set forth in the conversion contract shall be deemed to commence on the effective date of the enrollee's coverage under the prior group or individual contract.

(6) If an HMO does not issue individual or conversion contracts, the HMO may use a non-cancelable group contract to provide coverage for enrollees who are eligible for conversion coverage.

N. Extension of Benefits for Total Disability

(1) Each group contract issued by an HMO shall contain a reasonable extension of benefits upon discontinuance of the group contract with respect to enrollees who become totally disabled while enrolled under the contract and who continue to be totally disabled at the date of discontinuance of the contract.

(2) Upon payment of premium at the current group rate, coverage shall remain in full force and effect until the first of the following to occur:

(a) The end of a period of 180 days starting with the date of termination of the group contract;

(b) The date the enrollee is no longer totally disabled; or

(c) The date a succeeding carrier provides replacement coverage to that enrollee without limitation as to the disabling condition.

(3) Upon termination of the extension of benefits, the enrollee shall have the right to convert coverage as provided in Subsection M of this section.

O. Coordination of Benefits. The group or individual contract and evidence of coverage may contain a provision for coordination of benefits that shall be consistent with that applicable to other carriers in the jurisdiction. Any provisions or rules for coordination of benefits established by an HMO shall not relieve an HMO of its duty to provide or arrange for a covered health care service to an enrollee because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs. The HMO shall be required to provide covered health care services first and then, at its option, seek coordination of benefits.

P. Subrogation for Injuries Caused by Third Parties. The group or individual contract and evidence of coverage shall not contain any provisions concerning subrogation for injuries caused by third parties unless the wording has been approved by the commissioner.

Q. Description of the Service Area. The group or individual contract and evidence of coverage shall contain a description of the approved service area.

R. Entire Contract Provision. The group or individual contract shall contain a statement that the contract, all applications and any amendments thereto shall constitute the entire agreement between the parties. No portion of the charter, bylaws or other document of the HMO shall be part of the contract unless set forth in full in the contract or attached to it. However, the evidence of coverage may be attached to and made a part of the group contract.

S. Term of Coverage. The group or individual contract and evidence of coverage shall contain the time and date or occurrence upon which coverage takes effect, including any applicable waiting periods, or describe how the time and date or occurrence upon which coverage takes effect is determined. The contract and evidence of coverage shall also contain the time and date or occurrence upon which coverage will terminate.

T. Cancellation or Termination. The group or individual contract shall contain the conditions upon which cancellation or termination may be effected by the HMO, the group contract holder or the subscriber.

U. Renewal. The group or individual contract and evidence of coverage shall contain the conditions for, and any restrictions upon, the subscriber's right to renewal.

V. Reinstatement of Group or Individual Contract Holder. If an HMO permits reinstatement of a group or individual, the contract and evidence of coverage shall include any terms and conditions concerning reinstatement. The contract and evidence of coverage may state that all reinstatements are at the option of the HMO and that the HMO is not obligated to reinstate any terminated contract.

W. Grace Period

(1) The group or individual contract shall provide for a grace period of not less than thirty (30) days for the payment of any premium except the first, during which time the coverage shall remain in effect if payment is made during the grace period. The evidence of coverage shall include notice that a grace period exists under the group contract and that coverage continues in force during the grace period.

(2) During the grace period:

(a) The HMO shall remain liable for providing the services and benefits contracted for;

(b) The contract holder shall remain liable for the payment of premium for coverage during the grace period; and

(c) The subscriber shall remain liable for any copayments and deductibles.

(3) If the premium is not paid during the grace period, coverage is automatically terminated at the end of the grace period. Following the effective date of termination, the HMO shall deliver written notice of the termination to the contract holder.

X. Conformity with State Law. A group or individual contract and evidence of coverage delivered or issued for delivery in this state shall include a provision that states that any provision not in conformity with [cite section of law that sets forth the state's Health Maintenance Organization Act], this regulation or any other applicable law or regulation in this state shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the applicable laws and regulations of this state.

Y. Right to Examine Contract. An individual contract shall contain a provision stating that a person who has entered into an individual contract with a health maintenance organization shall be permitted to return the contract within ten (10) days of receiving it and to receive a refund of the premium paid if the person is not satisfied with the contract for any reason. If the contract is returned to the HMO or to the agent through whom it was purchased, it is considered void from the beginning. However, if services are rendered or claims are paid for the person by the HMO during the ten-day examination period and the person returns the contract to receive a refund of the premium paid, the person shall be required to pay for these services.

Section 7. Prohibited Practices

A. Preexisting Conditions

(1) An HMO may include in its individual contract a provision setting forth reasonable exclusions or limitations of services for preexisting conditions at time of enrollment. However, no such exclusions or limitations shall be for a period greater than two (2) years.

(2) An HMO shall not exclude or limit services for a preexisting condition when the enrollee transfers coverage from one individual contract to another or when the enrollee converts coverage under his conversion option, except to the extent of a preexisting condition limitation or exclusion remaining unexpired under the prior contract. Any required probationary or waiting period shall be deemed to have commenced on the effective date of coverage under the prior contract. The HMO contract shall disclose any preexisting condition limitations or exclusions that are applicable when an enrollee transfers from a prior HMO contract.

(3) A preexisting condition shall not be defined more restrictively than the following:

(a) The existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two-year period preceding the effective date of coverage under the health care plan; or

(b) A condition for which medical advice or treatment was recommended by a physician or received from a physician within a two-year period preceding the effective date of coverage under the health care plan.

(4) No group contract or evidence of coverage shall exclude or limit services for a preexisting condition.

B. Unfair Discrimination. An HMO shall not unfairly discriminate against an enrollee or applicant for enrollment on the basis of the age, sex, race, color, creed, national origin, ancestry, religion, marital status or lawful occupation of an enrollee, or because of the frequency of utilization of services by an enrollee. However, nothing shall prohibit an HMO from setting rates or establishing a schedule of charges in accordance with relevant actuarial data. An HMO shall not expel or refuse to re-enroll any enrollee nor refuse to enroll individual members of a group on the basis of the health status or health care needs of the individuals or enrollees.

Section 8. Services

A. Access to Care

(1) An HMO shall establish and maintain adequate arrangements to provide health services for its enrollees, including:

(a) Reasonable proximity to the business or personal residences of the enrollees so as not to result in unreasonable barriers to accessibility;

(b) Reasonable hours of operation and after-hours services;

(c) Emergency care services available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week; and

(d) Sufficient providers, personnel, administrators and support staff to assure that all services contracted for will be accessible to enrollees on an appropriate basis without delays detrimental to the health of enrollees.

(2) An HMO shall make available to each enrollee a primary care physician and provide accessibility to medically necessary specialists through staffing, contracting or referral. An HMO shall provide for continuity of care for enrollees referred to specialists.

(3) An HMO shall have written procedures governing the availability of services utilized by enrollees, including at least the following:

(a) Well-patient examinations and immunizations;

(b) Emergency telephone consultation on a twenty-four (24) hours per day, seven (7) days per week basis;

(c) Treatment of emergencies;

(d) Treatment of minor illness; and

(e) Treatment of chronic illnesses.

B. Basic Health Care Services. An HMO shall provide, or arrange for the provision of, as a minimum, basic health care service, which shall include the following:

(1) Emergency care services, as defined in Section 5 of this regulation;

(2) Inpatient hospital services, meaning medically necessary hospital services including, but not limited to, room and board; general nursing care; special diets when medically necessary; use of operating room and related facilities; use of intensive care units and services; x-ray, laboratory and other diagnostic tests; drugs, medications, biologicals, anesthesia and oxygen services; special nursing when medically necessary; physical therapy, radiation therapy and inhalation therapy; administration of whole blood and blood plasma; and short-term rehabilitation services;

(3) Inpatient physician care services, meaning medically necessary health care services performed, prescribed, or supervised by physicians or other providers including diagnostic, therapeutic, medical, surgical, preventive, referral and consultative health care services; and

(4) Outpatient medical services, meaning preventive and medically necessary health care services provided in a physician's office, a non-hospital-based health care facility or at a hospital. Outpatient medical services shall include but are not limited to diagnostic services; treatment services; laboratory services; x-ray services; referral services; and physical therapy, radiation therapy and inhalation therapy. Outpatient services shall also include preventive health services, which shall include at least a broad range of voluntary family planning services, services for infertility, well-child care from birth, periodic health evaluations for adults, screening to determine the need for vision and hearing correction, and pediatric and adult immunizations in accordance with accepted medical practice.

C. Out-of-Area Services and Benefits

(1) Out-of-area services shall be subject to the same copayment requirements set forth in Section 6F.

(2) When an enrollee is traveling or temporarily residing out of an HMO's service area, an HMO shall provide benefits for reimbursement for emergency care services and transportation that is medically necessary and appropriate under the circumstances to return the enrollee to an HMO provider, subject to the following conditions:

(a) The condition could not reasonably have been foreseen;

(b) The enrollee could not reasonably arrange to return to the service area to receive treatment from the HMO's provider;

(c) The travel or temporary residence must be for some purpose other than the receipt of medical treatments; and

(d) The HMO is notified by telephone within twenty-four (24) hours of the commencement of such care unless it is shown that it was not reasonably possible to communicate with the HMO in those time limits.

(3) Services received by a enrollee outside of the HMO's service area will be covered only so long as it is unreasonable to return the enrollee to the service area.

D. Supplemental Health Care Services. In addition to the basic health care services required to be provided in Subsection B above, an HMO may offer to its enrollees any supplemental health care services it chooses to provide. Limitations as to time and cost may vary from those applicable to basic health care services.

E. Non-Basic Health Care Services. An HMO may offer non-basic health care services to a group or individual on a prepaid basis, subject to the same conditions as for supplemental health care services, as described in Subsection D above, except that the HMO need not provide basic health care services as a condition to providing non-basic health care services.

Drafting Note: The intent of Subsections D and E above are to permit an HMO to provide coverages that are not basic health care services on either a supplement to basic health care services or on a stand-alone basis. The provisions of Subsection E above are not intended to permit the unbundling of basic health care services or the writing of limited forms of basic health care services on a free-standing basis. Subsection E may not be applicable unless state law permits single service HMOs.

Section 9. Other Requirements

A. Description of Providers

(1) An HMO shall provide its subscribers with a list of the names and locations of all of its providers no later than the time of enrollment or the time the group or individual contract and evidence of coverage are issued and upon reenrollment. If a provider is no longer affiliated with an HMO, the HMO shall provide notice of the change to its affected subscribers within thirty (30) days. Subject to the approval of the commissioner, an HMO may provide its subscribers with a list of providers or provider groups for a segment of the service area. However, a list of all providers shall be made available to subscribers upon request.

(2) A list of providers shall contain a notice regarding the availability of the listed primary care physicians. The notice shall be in not less than twelve-point type and be placed in a prominent place on the list of providers. The notice shall contain the following or similar language:

> "Enrolling in [name of HMO] does not guarantee services by a particular provider on this list. If you wish to receive care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for [name of HMO]."

B. Description of the Services Area. An HMO shall provide its subscribers with a description of its service area no later than the time of enrollment or the time the group or individual contract and evidence of coverage is issued and upon request thereafter. If the description of the service area is changed, the HMO shall provide at such time a new description of the service area to its subscribers.

C. Copayments and Deductibles. An HMO may require copayments or deductibles of enrollees as a condition for the receipt of specific health care services. Copayments for basic health care services shall be shown in the group or individual contract and evidence of coverage as a specified dollar amount. Copayments and deductibles shall be the only allowable charge, other than premiums, assessed to subscribers for basic, supplemental and non-basic health care services.

D. Grievance Procedure

(1) A grievance procedure shall be established and maintained by an HMO to provide reasonable procedures for the prompt and effective resolution of written grievances.

(2) An HMO shall provide grievance forms to be given to enrollees who wish to register written grievances. The forms shall include the address and telephone number to which grievances must be directed and shall also specify any required time limits imposed by the HMO.

(3) The grievance procedure shall provide for (i) written acknowledgement of grievances and (ii) grievances to be resolved or to have a final determination of the grievance by the HMO within a reasonable period of time, but not more than ninety (90) days from the date the grievance is received. This period may be extended (i) in the event of a delay in obtaining the documents or records necessary for the resolution of the grievance, or (ii) by the mutual written agreement of the HMO and the enrollee.

(4) Prior to the resolution of a grievance filed by a subscriber or enrollee, coverage may not be terminated for any reason that is the subject of the written grievance, except where the HMO has, in good faith, made a reasonable effort to resolve the written grievance through its grievance procedure and coverage is being terminated as provided for in Section 6H.

(5) If enrollee's grievances may be resolved through a specified arbitration agreement, the enrollee shall be advised in writing of his rights and duties under the agreement at the time the grievance is registered. Any such agreement must be accompanied by a statement setting forth in writing the terms and conditions of binding arbitration. Any HMO that makes binding arbitration a condition of enrollment shall fully disclose this requirement to its enrollees in the group or individual contract and evidence of coverage.

Section 10. Penalties

Any violation of this regulation shall be punished as provided for in [cite applicable section of law] and any other applicable law of this state.

Section 11. Severability

If any provision of this regulation or its application to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of the provision to other persons or circumstances shall not be affected.

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1987 Proc. I 11, 21, 22, 24-34 (adopted).
1991 Proc. I 9, 19-20, 86, 109-120 (amended and reprinted).