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18.01.26 - HEALTH MAINTENANCE ORGANIZATIONS

000. LEGAL AUTHORITY.
Title 41, Section 41-211, Idaho Code, Title 67, Chapter 52, Idaho Code, and Section 30 of House Bill No. 394, the Idaho Health Maintenance Organization Act, hereinafter referred to as the Act. (7-1-93)

001. TITLE AND SCOPE.
The purpose of this rule is to supplement the provisions of House Bill No. 394, the Health Maintenance Organization Act; to define procedures to be followed in establishing and operating an HMO; to define how certain of the powers of the HMO shall be exercised; to provide for the filing and approval of enrollee contracts and rates; to define procedures pertaining to open enrollment; to establish requirements for the bonding of officers and the organization; to define certain required reserves or liabilities; to establish requirements of certain reports to be furnished to the Director; to establish rules pertaining to the advertising of services provided by the HMO; to provide for the licensing or the registering of personnel and facilities and the maintaining of a list thereof; and to provide an effective date. (7-1-93)

002. -- 003. (RESERVED).

004. DEFINITIONS.

01. The Act. All terms defined in the Act which are used in this rule shall have the same meaning as used in the Act. (7-1-93)

02. HMO. Health Maintenance Organizations shall be abbreviated to HMO in this rule. (7-1-93)

03. Director. The term, Director, as referred to in this rule, shall mean the Director of the Department of Insurance, State of Idaho. NOTE: Senate Bill No. 1294, effective July 1, 1974, created the position of Director of the Department of Insurance to be the chief executive officer of that department and to assume the duties of the previous Commissioner of Insurance. (7-1-93)

005. -- 010. (RESERVED)

011. APPLICATION FOR CERTIFICATE OF AUTHORITY.

01. Certificate of Authority Required. The Act provides that an HMO shall not engage in business as an HMO unless so authorized under a Certificate of Authority issued by the Director of Insurance. (7-1-93)

02. Application. Application for a Certificate of Authority shall be submitted to the Director by the HMO not less than sixty (60) days prior to the date it proposes to engage in business in this state. (7-1-93)

03. Availability of Forms. Application forms will be furnished by the Director on the request of the HMO. (7-1-93)

04. Application Requirements. The application will specify the additional affidavits, statements and other information as enumerated in Section 5 and Section 6 of the Act, which are to be submitted with the application, except that after receiving these completed documents, the Director has the authority to request any supplemental information he deems necessary before final approval or disapproval is given. (7-1-93)

012. SOLICITATION PRIOR TO ISSUANCE OF CERTIFICATE OF AUTHORITY.

01. Permission for Solicitation Required. In accordance with Section 4, paragraph (2) of the Act, a proposed HMO, after filing its application for a Certificate of Authority, may request permission from the Director to inform potential enrollees concerning its proposed health maintenance services. (7-1-93)

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02. Solicitation Materials. Before contacting potential enrollees or subscribers, the proposed HMO shall submit its request for permission to the Director in writing, with copies of brochures, advertising or solicitation materials, sales talks or any other procedures or methods to be used. (7-1-93)

03. Requests of Methods of Solicitation. The Director may give approval for such methods of solicitation that he deems will meet certain requirements. Such requirements include, but are not limited to the following: (7-1-93)

a. The prospective enrollee shall clearly be advised that: (7-1-93)

i. The proposed HMO is not as yet authorized to offer health care services in this state; (7-1-93)

ii. Coverage for health care services is not being provided at the time of the solicitation; (7-1-93)

iii. The solicitation is not a guarantee that any services will be provided at a future date. (7-1-93)

b. The format and content of any material offered shall be in conformity with Section 023 of this rule. Such material shall contain but not be limited to the following information: (7-1-93)

i. Complete description of the proposed health maintenance services and other benefits to which the enrollee would be entitled; (7-1-93)

ii. The location of all facilities, the hours of operation, and the services which would be provided in each facility; (7-1-93)

iii. The predetermined periodic rate of payment for the proposed services; (7-1-93)

iv. All exclusions and limitations on the proposed services, including any copayment feature, and all restrictions relating to pre-existing conditions. (7-1-93)

c. No person shall solicit enrollment or inform prospective enrollees concerning proposed HMO services unless compensated solely as a salaried employee of the proposed HMO. (7-1-93)

d. Solicitation of "securities" in regard to an HMO must comply with Chapter 14, Title 30, Idaho Code. This chapter applies to any "security" as defined by 30-1402(12), Idaho Code, issued by, for or in behalf of an HMO. (7-1-93)

013. POWERS OF HMO, NOTICE OF INTENT REQUIRED.

01. Notice Requirements. Prior to exercising certain powers granted under Section 13 of the Act, the HMO shall give advance notice to the Director as follows: (7-1-93)

a. A notification of intent shall be filed with the Director not less than thirty (30) days prior to any commitment for purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, or any other property or properties which exceeds fifteen percent (15%) of the total assets of the organization at the time of said commitment. (7-1-93)

b. A notification of intent shall be filed with the Director not less than thirty (30) days prior to the making of a loan or loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and/or hospitals or in furtherance of a program providing health care services to enrollees if such loan or loans would exceed fifteen percent (15%) of the total assets of the organization at the time such loan or loans is to be made. (7-1-93)

c. Notification shall be given to the Director prior to the effective date of any substantial changes in agreements or contracts with reinsurers or other insurance carriers or providers of health care services. Copies of such agreements or contracts shall be filed with the Director at his request. (7-1-93)

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014. ANNUAL DISCLOSURE, FILING WITH DIRECTOR.
The HMO shall file with the Director a copy of all information required to be published and furnished each enrollee under Section 14 of the Act. This filing shall be made no later than the date it is furnished to the enrollees. (7-1-93)

015. ENROLLEE CONTRACTS.

01. Enrollee Contract Requirements. Each enrollee contract shall contain all information required under Section 15 of the Act, shall be the entire contract and wording to this effect shall be so stated therein. No additional restrictions, limitations or exclusions shall be imposed through any master contract or agreement entered into with any employer, provider of services, insurance carrier or any other person or persons. (7-1-93)

02. Form, Style and Text. Each enrollee contract shall be in a form, style, arrangement and text that is easily readable and understandable. (7-1-93)

03. Prior Approval Required. No enrollee contract shall be delivered or issued for delivery in this state until the form has been filed with and approved by the Director. (7-1-93)

04. Rates or Prepayments. (7-1-93)

a. Rates or prepayments to be charged the subscriber and/or enrollee shall be filed with the Director thirty (30) days prior to their effective date, and shall be accompanied by a description of the actuarial assumptions and analysis upon which such rates or prepayments are based. (7-1-93)

b. Rates or prepayments shall not be excessive, inadequate or unfairly discriminatory: (7-1-93)

i. A rate or prepayment will be considered excessive if it is not reasonable in relation to benefits provided; (7-1-93)

ii. A rate or prepayment will be considered inadequate if the use of such rate would endanger the solvency of the HMO, or would prevent the HMO from providing benefits according to the terms of the enrollee contract; (7-1-93)

iii. The rate or prepayment charged the enrollee or subscriber shall not discriminate between individuals of the same class as established by the HMO and of essentially the same hazard. (7-1-93)

c. On request, the HMO shall submit to the Director an opinion concerning the compliance of the rates or prepayments with the preceding Subsection 015.04.ii. Such opinion shall be written by a qualified member of the American Academy of Actuaries or by a person acceptable to the Director. (7-1-93)

016. OPEN ENROLLMENT.
Section 19 of the Act requires an annual open enrollment after the initial twenty-four (24) months of operation of the HMO. (7-1-93)

01. Open Enrollment Applicability and Exceptions. The open enrollment period shall be a period during which the HMO shall accept enrollments from the general public or from all members of the class of persons the HMO serves; except if an HMO is organized to provide services exclusively to a specified group or groups of individuals, such HMO may limit the open enrollment to all members of such group(s). (7-1-93)

02. Filing Regarding Projected Additional Enrollees. Not less than thirty (30) days prior to the opening date of the open enrollment period the HMO will file with the Director its projected number of additional enrollees to be accepted. Such filing shall include the basis upon which the HMO has determined the number relating to financial, facility or personnel capacity, or other considerations. (7-1-93)

03. Application for Underwriting Restrictions. Section 19(3) of the Act provides that the HMO may apply to the Director for authorization to impose underwriting restrictions on enrollments. Such application shall be made on a form furnished by the Director and shall be submitted to the Director not less than thirty (30) days prior to the commencement of the open enrollment period. The Director shall approve or disapprove the application within

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the thirty (30) day period. (7-1-93)

04. Length of Open Enrollment. The annual open enrollment shall be for a period of at least one (1) month and applications shall be accepted in the same order as received; except that, the open enrollment period may be terminated in less than one (1) month if the HMO has reached the limits of its capacity. (7-1-93)

05. Filing Results of Open Enrollment. At the close of the annual open enrollment period the HMO shall file with the Director the results of the enrollment, including the number of new enrollees. (7-1-93)

017. BONDING OF OFFICERS.

01. Certified Copy Required. A certified copy of the bond or bonds, as required under Section 23 of the Act, shall be furnished to the Director by the HMO. (7-1-93)

02. Cancellation Requirements. The bond shall contain an endorsement that it will be in effect until the Director has been notified. Notification of impending cancellation shall be furnished to the Director by the surety insurer no less than ten (10) days prior to cancellation. (7-1-93)

018. BONDING OF ORGANIZATION.

01. Bond Form. The license bond required by Section 24 of the Act will be on a form prescribed by and furnished by the Director. (7-1-93)

02. Bond Continous, Minimum twenty five thousand dollars ($25,000). The bond is to be continuous in form and in such amount as fixed by the Director, but in no event less than twenty five thousand dollars ($25,000). The amount of the bond will be fixed after a complete review of the application for a Certificate of Authority. (7-1-93)

03. Aggregate Liability. The aggregate liability on the bond shall be limited to payment not exceeding the amount stated in the bond. (7-1-93)

019. LIABILITIES, RESERVES AND OTHER FUNDS.
Section 25 of the Act requires that each HMO shall establish and maintain certain unimpaired reserves; therefore, the liabilities shown on the annual report to the Director shall include, but not be limited to: (7-1-93)

01. Legal Obligations. All legal obligations of the organization, other than claims, by major category. (7-1-93)

02. Unpaid Claims. All unpaid claims, including a reasonable additional amount for incurred claims not yet reported. (7-1-93)

03. Deferred Benefits. A reasonable amount to pay deferred maternity benefits and similar deferred service benefits. (7-1-93)

020. ANNUAL REPORT TO THE DIRECTOR.

01. Annual Report, Certification. The report to the Director required under Section 10 of the Act shall be on forms as prescribed by the Director. There shall be a certification by an independent public accountant attached to the report. (7-1-93)

02. Requirements of Annual Report. Section 18 of the Act, pertaining to the grievance system, requires that the HMO shall submit an annual report to the Director, on a form prescribed by him, which shall include but not be limited to: (7-1-93)

a. A description of the procedures of the complaint system. (7-1-93)

b. The total number of complaints handled through the complaint system and a compilation of causes

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underlying the complaints filed. (7-1-93)

021. ENROLLEE PARTICIPATION.
Section 16(2) of the Act requires that a mechanism be established by the governing body to provide enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other reasonable mechanisms. (7-1-93)

01. Advisory Panel Membership. Since the fundamental principle of any HMO is to make itself responsive to the needs of its enrollees, a majority of the members of the advisory panel shall be enrollees who are not also providers. (7-1-93)

02. Advisory Panel Duties. The advisory panel shall review and comment upon any proposed changes in the complaint system, benefit packages or prepayments prior to the implementation of such changes. The substance of these comments on all proposed changes, instituted or not instituted, shall be furnished to all enrollees with the notification of any such changes. (7-1-93)

03. Grievance Procedure. Section 18(4) Of the Act requires that the HMO shall show evidence that the advisory panel has reviewed and approved the grievance procedure. (7-1-93)

022. COMPLAINT SYSTEM.
Section 18 of the Act requires that a complaint system be established to resolve complaints initiated by enrollees concerning health care services. (7-1-93)

01. Requirements of Compliance System. The system shall be designed to assure that the complaint will be handled expeditiously, fairly and with sensitivity, and provide the enrollee with an adequate means of review by the governing body. (7-1-93)

02. Retention of Complaint Records Required. Adequate records of all complaints received and action taken shall be maintained at all times, and shall be available for examination by the Director. (7-1-93)

a. A summary report of all complaints shall be furnished the Director at his request. (7-1-93)

b. Complaints involving other persons shall he referred to such persons with a copy to the Director. (7-1-93)

023. ADVERTISING.
The HMO shall comply with 18.01.24, Rules of the Department of Insurance, promulgated under Title 41, Chapter 13, Idaho Code, to the extent applicable and not in conflict with the express provisions of the Act and the reasonable implications of such express provisions. For the purpose of the application of 18.01.24, the HMO shall be deemed to be an "insurer." (7-1-93)

024. LICENSING OR REGISTERING OF PERSONNEL AND FACILITIES REQUIRED.

01. License or Registration of HMO Employees, Etc. All employees of the HMO, or other persons retained by, or under contract to provide health services for the HMO, which by the nature of such health services would otherwise be required to be licensed or registered by an agency of the state, shall be so licensed or so registered. (7-1-93)

02. License or Registration of HMO Hospital, Clinic, Etc. Any hospital, clinic or other facility owned by, under contract to, under the control of, or in any manner utilized by the HMO to furnish health services, which by the nature of such health services would otherwise be required to be licensed or registered by an agency of the state, shall be so licensed or so registered. (7-1-93)

025. PERSONNEL AND FACILITIES LISTING REQUIRED.
The HMO shall at all times keep a current list of all personnel, providers and facilities employed, retained or under contract to furnish health care services to enrollees. This list shall be available to the Director at his request. (7-1-93)

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026. SEVERABILITY CLAUSE.
If any provision of this rule, or the application thereof to any person or circumstance, is held invalid, the remainder of the rule, or the applicability of such provision to other persons or circumstances, shall not be affected thereby. (7-1-93)

027. -- 999. (RESERVED).

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