§4202-A. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [PL 1991, c. 709, §2 (NEW).]

1. Basic health care services. "Basic health care services" means health care services that an enrolled population might reasonably require in order to be maintained in good health and includes, at a minimum, emergency care, inpatient hospital care, inpatient physician services, outpatient physician services, ancillary services such as x-ray services and laboratory services and all benefits mandated by statute and mandated by rule applicable to health maintenance organizations. The superintendent may adopt rules defining "basic health care services" to be provided by health maintenance organizations. In adopting such rules, the superintendent shall consider the coverages that have traditionally been provided by health maintenance organizations; the need for flexibility in the marketplace; and the importance of providing multiple options to employers and consumers. The superintendent shall permit reasonable, but not excessive or unfairly discriminatory, variations in the copayment, coinsurance, deductible and other features of coverage, except that these features must meet or exceed those required in benefits mandated by statute. The superintendent shall permit deductible, coinsurance and copayment levels consistent with the deductible levels permitted for policies issued pursuant to chapter 33 or 35. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2011, c. 90, Pt. F, §4 (AMD).]

2. Capitated basis. "Capitated basis" has the following meanings.

A. "Capitated basis" means fixed per-member, per-month payments or percentage-of-premium payments pursuant to which the provider assumes full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities. [PL 1991, c. 709, §2 (NEW).]

B. "Capitated basis," in the context of a point-of-service option plan, means prepayment that considers provision of in-plan covered services as described in paragraph A and that considers out-of-plan indemnity benefits reimbursed pursuant to the terms of a point-of-service product approved pursuant to section 4207-A. [PL 1991, c. 709, §2 (NEW).]
[PL 1991, c. 709, §2 (NEW).]

3. Carrier. "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital, a medical service corporation or any other entity responsible for the payment of benefits or provision of services under a group contract.
[PL 1991, c. 709, §2 (NEW).]

4. Copayment. "Copayment" means an amount an enrollee must pay in order to receive a specific service that is not fully prepaid.
[PL 1991, c. 709, §2 (NEW).]

5. Deductible. "Deductible" means the amount an enrollee is responsible to pay out of pocket before a health maintenance organization begins to pay the costs associated with treatment.
[PL 1991, c. 709, §2 (NEW).]

6. Enrollee. "Enrollee" means an individual who is enrolled in a health maintenance organization.
[PL 1991, c. 709, §2 (NEW).]

7. Evidence of coverage. "Evidence of coverage" means any certificate, agreement or contract issued to a group contract holder or an enrollee setting out the coverage to which an enrollee is entitled.
[PL 1991, c. 709, §2 (NEW).]

8. Group contract holder. "Group contract holder" means an entity or person that has purchased coverage from a health maintenance organization that provides, at a minimum, basic health care services to enrollees.
[PL 1991, c. 709, §2 (NEW).]

9. Health care services. "Health care services" means any services included in the furnishing of medical care, dental care or hospitalization to an individual, or any services incident to the furnishing of that care or hospitalization, as well as the furnishing of any other services to an individual to prevent, alleviate, cure or heal human illness or injury.
[PL 1991, c. 709, §2 (NEW).]

10. Health maintenance organization. "Health maintenance organization" means a public or private organization that is organized under the laws of the Federal Government, this State, another state or the District of Columbia or a component of such an organization, and that:

A. Provides, arranges or pays for, or reimburses the cost of, health care services, including, at a minimum, basic health care services to enrolled participants, except that health maintenance organizations contracting with the State Government or the Federal Government to service Medicaid or Medicare populations may limit the services they provide under the contracts consistent with the terms of those contracts if such basic health care services are provided to those populations by other means; [PL 1995, c. 673, Pt. D, §1 (AMD).]

B. Is compensated, except for reasonable copayments, for basic health care services to enrolled participants solely on a predetermined periodic rate basis, except that the organization is not prohibited from having a provision in a group contract allowing an adjustment of premiums based upon the actual health services utilization of the enrollees covered under the contract, and except that such a contract may not be sold to an eligible group subject to the community rating requirements of section 2808-B; [PL 1993, c. 645, Pt. A, §5 (AMD).]

C. Provides physicians' services primarily directly through physicians who are either employees or partners of that organization or through arrangements with individual physicians or one or more groups of physicians organized on a group-practice or individual-practice basis under which those physicians or groups are provided effective incentives to avoid unnecessary or unduly costly utilization, regardless of whether a physician is individually compensated primarily on a fee-for-service basis or otherwise. The organization may discharge its obligation through a point-of-service option product by reimbursing out-of-plan providers pursuant to the terms contained in the group contract holder's group contract. Receipt of out-of-plan covered services by an enrollee does not obligate the organization for an enrollee's responsibilities to meet copayments or deductibles; and [PL 1991, c. 709, §2 (NEW).]

D. Ensures the availability, accessibility and quality, including effective utilization, of the health care services that it provides or makes available through clearly identifiable focal points of legal and administrative responsibility. [PL 1991, c. 709, §2 (NEW).]

Nothing in this subsection prevents a health maintenance organization from providing fee-for-service health care services as well as health maintenance organization services. A health care provider or affiliated entity that does not offer health insurance or health benefit plans may not be or become a health maintenance organization subject to this chapter solely by reason of arrangements with insurers or hospital or medical service organizations for reimbursement in whole or in part on a capitated basis, the financial risk to the provider or affiliated entity associated with reimbursement arrangements with such 3rd-party payors or the furnishing by the provider or affiliated entity of utilization or case management services.
[PL 1995, c. 673, Pt. D, §1 (AMD).]

11. In-plan covered services. "In-plan covered services" means covered health care services obtained from providers who are employed by, under contract with, referred by or otherwise affiliated with the health maintenance organization. "In-plan covered services" includes emergency services.
[PL 1991, c. 709, §2 (NEW).]

12. Nonprofit hospital or medical service organization. "Nonprofit hospital or medical service organization" means any organization defined in and authorized to act under Title 24, chapter 19.
[PL 1991, c. 709, §2 (NEW).]

12-A. NCQA accreditation survey report. "NCQA accreditation survey report" means the unpublished, detailed survey report to a health maintenance organization by the National Committee for Quality Assurance upon completion of NCQA's accreditation survey of the health maintenance organization.
[PL 1999, c. 256, Pt. Q, §1 (NEW).]

13. Out-of-plan covered services. "Out-of-plan covered services" means nonemergency, covered health care services obtained without a referral from providers who are not otherwise employed by, under contract with or otherwise affiliated with the health maintenance organization or from affiliated specialists.
[PL 1991, c. 709, §2 (NEW).]

14. Participating provider. "Participating provider" means a provider as defined in subsection 18 that, under an express or implied contract with a health maintenance organization, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment, directly or indirectly from the health maintenance organization.
[PL 1991, c. 709, §2 (NEW).]

15. Person. "Person" means an individual, firm, partnership, corporation, association, syndicate, organization, society, business trust, attorney-in-fact or any legal entity.
[PL 1991, c. 709, §2 (NEW).]

16. Point-of-service option. "Point-of-service option" means a health maintenance organization product that allows an enrollee to select either the comprehensive health care benefits of the health maintenance organization or care from a provider of the enrollee's choice outside the health maintenance organization network with traditional indemnity benefits. A point-of-service option in which the risk for out-of-plan covered services of a health maintenance organization is shared with a reinsurer must meet the requirements of this chapter applicable to the indemnity benefits provided by a health maintenance organization.
[PL 1991, c. 709, §2 (NEW).]

17. Point-of-service product. "Point-of-service product" means a product that includes both in-plan covered services and out-of-plan covered services.
[PL 1991, c. 709, §2 (NEW).]

18. Provider. "Provider" means a physician, hospital or person that is licensed or otherwise authorized in this State to furnish health care services.
[PL 1991, c. 709, §2 (NEW).]

19. Superintendent. "Superintendent" means the Superintendent of Insurance.
[PL 1991, c. 709, §2 (NEW).]

20. Uncovered expenditures. "Uncovered expenditures" means costs to a health maintenance organization for health care services that are the obligation of the health maintenance organization for which an enrollee may also be liable.
[PL 1991, c. 709, §2 (NEW).]

SECTION HISTORY

PL 1991, c. 709, §2 (NEW). PL 1993, c. 645, §A5 (AMD). PL 1995, c. 673, §D1 (AMD). PL 1999, c. 222, §1 (AMD). PL 1999, c. 256, §Q1 (AMD). PL 2001, c. 218, §1 (AMD). PL 2011, c. 90, Pt. F, §4 (AMD).