§4207-A. Point-of-service products

1. Product design; mandatory requirements. A point-of-service product, filed and approved for use subject to the requirements of section 4207, subsection 4, at a minimum must:

A. Provide all services required by law to be provided by health maintenance organizations as in-plan covered services, including emergency services; [PL 1991, c. 709, §5 (NEW).]

B. Provide incentives for enrollees to use in-plan covered services; and [PL 1991, c. 709, §5 (NEW).]

C. Offer out-of-plan covered services only if those services are provided by the point-of-service product on an in-plan basis. [PL 1991, c. 709, §5 (NEW).]

[PL 1991, c. 709, §5 (NEW).]

2. Product design; optional provisions. A point-of-service product may:

A. Limit or exclude specific types of services from coverage when obtained out of plan; [PL 1991, c. 709, §5 (NEW).]

B. Include annual out-of-pocket limits and annual and lifetime maximum benefit allowances for out-of-plan covered services that are separate from any limits and allowances applied to in-plan covered services; [PL 1991, c. 709, §5 (NEW).]

C. Limit the groups to which the point-of-service product is offered. If the point-of-service product is offered to a group, it must be offered to all eligible members of that group; and [PL 1991, c. 709, §5 (NEW).]

D. Include those services that an enrollee obtains from a participating physician for which proper authorization was not given. [PL 1991, c. 709, §5 (NEW).]

[PL 1991, c. 709, §5 (NEW).]

3. Product limitations and exclusions. A health maintenance organization is subject to the following requirements as to its point-of-service product.

A. A health maintenance organization may not expend more than 20% of its total annual health care expenditures for out-of-plan covered services. [PL 1991, c. 709, §5 (NEW).]

B. If compliance with the amount specified in paragraph A is not demonstrated on a quarterly basis in a health maintenance organization's quarterly financial report, the superintendent may prohibit the health maintenance organization from offering a point-of-service product for new issues or for the renewal of existing contracts until compliance has been demonstrated. [PL 1991, c. 709, §5 (NEW).]

[PL 1991, c. 709, §5 (NEW).]

4. Plan requirements. A health maintenance organization may not issue a point-of-service product until it has filed and has had approved by the superintendent a plan to comply with this section, including, in addition to any other requirements of this section, group contracts, subscriber contracts and other materials used by enrollees.

A. Marketing materials must be filed upon request of the superintendent. Member handbooks must be filed for approval only when the initial point-of-service plan is filed and when substantial modifications are made in the point-of-service plan that change policy terms respecting benefits or change the manner in which enrollees may access provider services. [PL 1991, c. 709, §5 (NEW).]

B. The plan must include, but is not limited to, provisions demonstrating that the health maintenance organization will:

(1) Design the benefit levels for in-plan covered services and out-of-plan covered services to achieve the desired level of in-plan utilization; and

(2) Provide or arrange for the provision of adequate systems to:

(a) Process and pay claims for out-of-plan covered services;

(b) Meet the requirements of a point-of-service product as set by this section or by rule of the superintendent; and

(c) Generate accurate financial and regulatory reports on a timely basis in order for the superintendent to evaluate experience with the point-of-service product and monitor compliance with point-of-service product provisions. [PL 1991, c. 709, §5 (NEW).]

[PL 1991, c. 709, §5 (NEW).]

5. Claims processing. Explanation of benefits given to an enrollee of a point-of-service plan must contain an explanation of coverage for self-referral health care services that is adequate to permit an enrollee to determine claims liability under the plan.

[PL 1991, c. 709, §5 (NEW).]

5-A. Assignment of benefits. All point-of-service contracts and certificates must contain a provision permitting the insured to assign any benefits provided for medical or dental care on an expense-incurred basis to the provider of the care. An assignment of benefits under this subsection does not affect or limit the payment of benefits otherwise payable under the contract or certificate.

[PL 1999, c. 21, §4 (AMD).]

6. Disclosure. All marketing materials, subscriber contracts, member handbooks or other material used by enrollees must contain a clear and concise explanation of point-of-service health care services. The explanation must include:

A. The method of reimbursement; [PL 1991, c. 709, §5 (NEW).]

B. Applicable copayments and deductibles; [PL 1991, c. 709, §5 (NEW).]

C. Other uncovered costs or charges; [PL 1991, c. 709, §5 (NEW).]

D. The services that an enrollee is permitted to obtain on a self-referral basis; and [PL 1991, c. 709, §5 (NEW).]

E. Instructions regarding submission of claims for self-referred health care services. [PL 1991, c. 709, §5 (NEW).]

[PL 1991, c. 709, §5 (NEW).]

SECTION HISTORY

PL 1991, c. 709, §5 (NEW). PL 1997, c. 604, §E4 (AMD). PL 1999, c. 21, §4 (AMD).