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HEALTH POLICY MEMORANDUM NUMBER 98-01

Health Maintenance Organizations

STATUTORY OBLIGATIONS OF HEALTH MAINTENANCE ORGANIZATIONS

AUTHORITY

LSA-R.S. 22:2002(7), R.S. 22:2002(5), R.S. 22:2002(8), R.S. 22:2004, R.S. 22:2005(A)(3), R.S.22:2013(A), R.S.22:2013(A)(1)(2) and (6), R.S.22:2013(B), R.S.22:2016(C) and (D), R.S. 22:2018, R.S. 22:2021(B), R.S. 22:2026, and R.S. 22:1217

BACKGROUND

Some health maintenance organizations (HMOs) are failing to provide or arrange for provision of medically necessary services, and/or delaying other contractual services to enrollees. Further, some HMOs are not complying with the terms of the respected provider contracts that have been filed with and approved by the Louisiana Department of Insurance. Based on the statutory requirements set forth in the Louisiana insurance code, LSA-R.S. 22:1 et. seq., every HMO conducting business in this state should immediately review its contracts and records to assure full compliance with the following statutory obligations:

OBLIGATIONS

LSA-R.S. 22:2002(7) states:

> "Health maintenance organization" means any corporation organized and domiciled in this state which undertakes to provide or arrange for the provision of basic health care services to enrollees in return for a prepaid charge. The health maintenance organization may also provide or arrange for the provision of other health care services to enrollees on a prepayment or other financial basis. A health maintenance organization is deemed to be an insurer for the purposes of R.S. 22:213.6 and 213.7, part XVI, comprised of R.S. 22:731 through 774, part XXI-A, comprised of R.S. 22:1001 through 1015, and part XXVI-B, comprised of LSA-R.S. 22:1241

through 1247.1, of chapter 1 of this title. A health maintenance organization shall not be considered an insurer for any other purpose."

LSA-R.S. 22:2002(5) states:

> "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which the enrollee is entitled by reason of payment of a prepaid charge."

LSA-R.S. 22:2002(8) states:

> "Provider means any physician, hospital, or other person, organization, institution, or group of persons licensed or otherwise authorized in this state to furnish health care services."

- **HMOS' OBLIGATION TO PROVIDE OR ARRANGE FOR PROVISION OF COVERED MEDICAL SERVICES**

  In accordance with the above quoted statutes:

  The primary obligation of an HMO is to provide or arrange for basic health care services, or medically necessary care as mandated in the evidence of coverage. The penalty for the failure of a plan to fulfill this obligation is suspension or revocation of the HMO's certificate of authority under LSA-R.S. 22:2013(A)(1)(2) and (6). Furthermore, the HMO act, LSA-R.S. 22:2001 et. Seq., places no obligation on enrollees to self-direct their care or to supervise the plan's practitioners.

  LSA-R.S. 22:2021(B) clearly establishes that the obligation to obtain any prior authorization for the delivery of health care and treatment services to the enrollees, rests with the health care provider whether employed or contracted by the managed care organization. In which case, when an enrollee seeks covered medical services from an authorized provider of the plan, that provider is obligated to fulfill all contractual responsibilities for the delivery of covered services. Therefore, as the HMO's duly authorized representative, the provider's authorization for medically necessary services constitutes provision of health care services prescribed in the evidence of coverage.

  Pursuant to LSA-R.S. 22:2018(B), an authorized provider who does not have a written contract must look to the HMO for payment of covered services delivered. The HMO's obligation, however, is limited to payment for the authorized service, at the same rate that would have been paid to other providers rendering the same service. The HMO may adopt provider standards for participation or payment. Such standards may require the referring provider to assume financial liability for any additional amounts legally owed to such physicians, excluding the plan member's standard co-payment amount when such referrals have not been approved by the HMO.

LSA-R.S. 22:2016(C) provides that every HMO shall make available to its potential enrollees a reasonable explanation of the services to be arranged for or provided. This explanation shall also identify those services excluded from coverage and shall set forth the methods of access to all forms of treatment or class of providers included in the plan.

HMOs are obligated to comply with its providers' independent medical judgment as mandated by LSA-R.S. 22:2016(D). Nevertheless, the HMO has the authority to implement guidelines to assure that its providers comply with prior authorization, utilization review, and other statutory requirements. Further, an HMO has the authority to establish compliance requirements that include, but are not limited to, payment adjustments or termination for cause.

In compliance with LSA-R.S. 22:2016(C), where an enrollee is issued a prescription by the primary care provider or authorized referral physician, the HMO is obligated to provide the enrollee with the duly ordered medication. The HMO will not be liable for provision of the following:

A. Any prescriptions issued to an enrollee whose coverage does not include coverage of prescription drugs; or

B. A prescription for a drug that is specifically excluded from coverage under the excluded benefits provisions of the prepaid individual or group coverage (a formulary does not meet the specific notice requirements necessary to establish coverage exclusions).

The plan may establish reasonable administrative guidelines to assure enrollees are receiving appropriate medications recommended by the HMO. In the event the treating physician is not available when the enrollee presents a written prescription for medication **not included on a formulary**, the HMO should have reasonable standards to assure medical treatment is provided. A 48-72 hour supply of the ordered drug may be filled by the pharmacist in order for the HMO to fulfill its obligation to provide covered services which are medically necessary. In such cases, the pharmacist shall not apply a co-payment for filling such prescription until such time the ordered medication or an acceptable substitute is provided.

HMOs that issue minimum supplies of medications ordered by treating physicians must establish administrative procedures to assure the enrollee will receive appropriate medication within the period established by the plan. In no instance shall an enrollee be denied medical treatment based on a provider's violation of treatment guidelines or prior authorization procedures, as provided in LSA-R.S. 22:2016(D).

- **PROVIDER OBLIGATIONS**

  Pursuant to LSA-R.S. 22:2018(A)(1), if the primary care provider violates the HMO's referral protocols, expenses incurred from such violation shall not be charged to the enrollee. Hence, no enrollee shall be subjected to "balance billing". The enrollee is held harmless from any liability for sums owed by the HMO. If it is determined that "balance billing" has occurred, the HMO may assess the provider with civil/monetary penalties.

- **ENROLLEE OBLIGATIONS**

  LSA-R.S. 22:2026 establishes the obligations of enrollees in accessing covered medical services. Under LSA-R.S. 22:2026(C), every subscriber and enrollee shall be provided with a written notice which fully explains all copayment and deductible amounts applicable to all covered services, as well as limitations on choice of primary care physicians, access to specialists, and application of preeexisting medical condition exclusions from coverage. Failure of the HMO to make such disclosures constitutes an unfair trade practice and is subject to penalties provided for in LSA-R.S. 22:1217.

- **REGULATORY COMPLIANCE**

  LSA-R.S. 22:2004 establishes the statutory requirement to file the form of provider contracts with this department and describes the method of providing health care services to enrollees. LSA-R.S. 22:2005(A)(3) establishes the authority of the department to consider the financial soundness of the arrangements for provision of health care services and the schedule of charges used in connection therewith. Additionally, LSA-R.S. 22:2018 specifically requires all provider contracts to include the methodology by which payment will be made.

  In granting a certificate of authority to operate an HMO, the plan is obligated to follow the terms and conditions of all documents filed for approval with this department. Failure to provide reimbursement in accordance with the methodology reviewed and approved by this department is a violation of LSA-R.S. 22:2013(A)(1), (6), and (8).

  Violation of any provision of LSA-R.S. 22:2013(A) is grounds for revocation or suspension of an HMO's certificate of authority. Because suspension or revocation of the certificate of authority for violation of LSA-R.S. 22:2013(A) would cause irreparable harm or substantial monetary loss to the plan; such violations shall be subject to fines as provided under LSA-R.S. 22:2013(B). Those fines are $1,000 per violation with a maximum amount of $100,000 per calendar year.

  However, repeated violations of LSA-R.S. 22:2013(A) may subject the HMO to additional fines and penalties under the unfair trade practices act, LSA-R.S.

22:1217. Where the department finds that an HMO has established a practice of repeated violations, the plan will be subject to suspension or revocation of its certificate of authority as provided in LSA-R.S. 22:2013.

By:

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