ALABAMA DEPARTMENT OF INSURANCE
INSURANCE REGULATION

CHAPTER 482-1-080

LIABILITIES OF HEALTH MAINTENANCE ORGANIZATIONS

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482-1-080-.01 Purpose. The purpose of this chapter is to provide for consistent accounting for liabilities of Health Maintenance Organizations (HMO) licensed in Alabama.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-21A-19 and 27-2-17
History: New April 22, 1987, Effective May 8, 1987; Revised October 3, 1988, Effective October 20, 1988; Revised April 19, 1996, Effective May 1, 1996

482-1-080-.02 Authority. This chapter is made and promulgated by the undersigned Commissioner pursuant to the authority set forth in Sections 27-21A-19 and 27-2-17 Code of Alabama, 1975 and to replace Regulation No. 80 promulgated on October 20, 1988.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-21A-19 and 27-2-17
History: New April 22, 1987, Effective May 8, 1987; Revised October 3, 1988, Effective October 20, 1988; Revised April 19, 1996, Effective May 1, 1996

482-1-080-.03 Applicability and Scope. Except as otherwise specifically provided, this chapter shall apply to Health Maintenance Organizations licensed in Alabama.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-21A-19 and 27-2-17
History: New April 22, 1987, Effective May 8, 1987; Revised October 3, 1988, Effective October 20, 1988; Revised April 19, 1996, Effective May 1, 1996

482-1-080-.04 Definitions. The following are the meanings to be applied to the terms used in this chapter:

(1) UNCOVERED EXPENDITURES. The costs of health care services which are covered by a health maintenance organization, for which an enrollee would also be liable in the event of the organization's insolvency.

(2) COVERED EXPENDITURES. Liabilities for the costs of health care services not included in uncovered expenditures.

(3) ACCOUNTS PAYABLE. Amounts due to creditors for the acquisition of goods and services on a credit basis from trade and other vendors other than health care providers.

(4) ACCRUED INPATIENT CLAIMS. Hospital and institutional care claims incurred which are not reported and/or booked as payables, including Incurred But Not Reported Claims.

(5) ACCRUED PHYSICIAN CLAIMS. Claims incurred for physicians and ancillary services (such as laboratory and x-ray) by providers under an arrangement with the Health Maintenance Organization.

(6) ACCRUED REFERRAL CLAIMS. Claims incurred for health care provider consultants and for referrals to providers outside a Health Maintenance Organization arrangement or for a professional service contract which is usually paid on a fee-for-service basis outside of the usual contractual provider arrangements of the HMO.

(7) ACCRUED OTHER MEDICAL EXPENSES. Other incurred medical expenses including emergency room, out-of-area services, payroll and other miscellaneous medical expenses.

(8) ACCRUED MEDICAL INCENTIVE POOL. The accrual for withheld funds from individual practice associations, other medical groups or other such arrangements in which the Health Maintenance Organization may return incentive funds to providers.

(9) UNEARNED PREMIUM. Income received or booked in advance of the applicable payment period for which a liability exists to render services in the future.

(10) LOANS AND LOANS PAYABLE. The principal amounts on loans signed by the Health Maintenance Organization or for which the Health Maintenance Organization is liable and are amounts which include federal loans.

(11) CAPITAL. The par value of stock; the stated amount of owner's direct equity in the Health Maintenance Organization for a stock HMO. For a partnership HMO, capital shall mean the amount of the partners' equity or ownership accounts.

(12) RESTRICTED FUNDS. Funds of the Health Maintenance Organization which have been dedicated to specific groups or purposes by the Health Maintenance Organization's governing body. This includes but is not limited to declared dividends and group trust accounts.

(13) CAPITAL ACCOUNT. Capital Account of an HMO shall be defined as the total of paid-in stated capital which is the total of the par value for stock having par value or the amount of the consideration received by the corporation for all shares of the corporation without par value which have been issued plus such amounts which have been transferred to stated capital in a manner permitted by law for a corporation or the total of the partners' equity account in the case of a partnership. The amount shall not be less than $100,000 for any licensed HMO and shall be maintained without diminution or impairment while the HMO is licensed. This is the legal capital of the HMO.

(14) IMPAIRMENT OR INSOLVENCY. A Health Maintenance Organization shall be deemed to be impaired or insolvent when the HMO does not possess admitted assets at least equal to its liabilities and capital account. A Health Maintenance Organization shall be rehabilitated, liquidated or conserved under any of the reasons as set forth in Sections 27-21A-18 and 27-32-6, Code of Alabama 1975.

(15) ADMITTED ASSETS. Those assets which are assets which are legally admissible assets of life insurers and include assets as allowable only in the amounts and qualifications as described in Sections 27-41-1, et seq., Code of Alabama 1975. The valuation of admissible assets are as determined according to Sections 27-37-1, et seq., Code of Alabama, 1975. Any investment limitations based on a life insurance company's capital and surplus in these preceding sections shall instead be based on the capital account and deposit requirement amounts found in Section 27-21A-12 Code of Alabama 1975.

(16) UNCOVERED LIABILITIES. Obligations resulting from unpaid uncovered expenditures, the outstanding indebtedness of loans which are not specifically subordinated to uncovered medical and health care expenses or guaranteed by the sponsoring organization (guaranteeing person), and all other monetary obligations which are not similarly subordinated or guaranteed by subordination agreements, sponsoring organization guarantees, or other arrangements these covered expenditures, subordinated indebtedness, guarantees, and other arrangements must be acceptable to the Commissioner and must be accepted by written approval of the Commissioner.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-21A-19 and 27-2-17
History: New April 22, 1987, Effective May 8, 1987; Revised October 3, 1988, Effective October 20, 1988; Revised April 19, 1996, Effective May 1, 1996

482-1-080-.05 Liabilities Generally of Health Maintenance Organizations.

(1) In any determination of the financial condition of a Health Maintenance Organization, capital and liabilities to be charged against its admitted assets shall include:

(a) The amount of its capital account which consists of minimum capital stock of $100,000 in the form of paid-in capital for a stock HMO and a paid-in partners share account in the case of a HMO which is a partnership. The required annual deposit and the preliminary deposit made with the State Treasurer are in addition to this capital requirement.

(b) The amount estimated as necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, including claims payable, accrued inpatient claims, accrued physician claims, accrued referral

claims, accrued other medical expenses, accrued medical incentive pool, and other accrued health related services including covered and uncovered expenditures.

The loss or claims reserves, provisions for experience rating refunds including the accrued medical incentive pool, and any other actuarial items are to be certified by a qualified actuary who is a member in good standing of the American Academy of Actuaries, or a person recognized by the American Academy of Actuaries as qualified for such actuarial valuation, or a person who otherwise has demonstrated his competency in such actuarial evaluation to the satisfaction of the Commissioner.

(c) Any loans and notes payable.

However, a HMO may borrow money to provide it with surplus funds in excess of the required $100,000 capital account and $100,000 unimpaired surplus upon a written agreement which such is required to be repaid only out of the HMO's earned surplus in excess of which stipulated in such agreement; if the lender of the funds agrees to defer any interest and/or principal repayments until the capital and surplus of the HMO equals the minimum $1,800,000 capital and surplus required of a licensed life insurer; and also if the lender subordinates the debt to all other HMO creditors. The agreement may provide for interest at a reasonable rate per annum, which interest shall, or shall not, constitute a liability of the HMO as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan.

Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the HMO's legal accrued liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement or be the basis of any setoff, but, until repaid, financial statements filed or published by the HMO shall show as a "write-in" line thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

Any such loan shall be subject to the Commissioner's approval. The HMO shall, in advance of the loan, file with the Commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement along with a detailed listing of all securities to be received in exchange for the note. The Commissioner shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended or which the terms of the loan agreement are not fair and equitable to the parties and to other similar lenders, if any, to the HMO or which the information so filed by the HMO is inadequate.

Any such loan, or substantial portion thereof, shall be repaid by the HMO when no longer reasonably necessary for the purpose originally intended. No repayment of such a loan shall be made, unless in advance approved by the Commissioner.

The value of the surplus note issued under this section shall not be considered as the deciding authority for valuing the assets received for the above note, but shall only be taken into account with all other factors in determining admitted value.

An HMO domiciled in a state other than Alabama shall first obtain the written approval of any surplus note from its domiciliary state's insurance Commissioner or other state authority that regulates HMO before seeking approval of the note by the Commissioner.

(d) The amount of reserves equal to the unearned portions of the gross premiums and other fees charged on contracts in force, computed in accordance with procedures approved by the Commissioner.

The Health Maintenance Organization may compute all of such reserves on a monthly or more frequent pro rata basis. However, after adopting a method for computing such reserve, a Health Maintenance Organization shall not change methods without approval of the Commissioner;

(e) Taxes, expenses and other obligations due or accrued at the date of the statement; and

(f) Any additional reserves which may be required by the Commissioner consistent with practice as last formulated or approved by the National Association of Insurance Commissioners or its successor organization, on account of such business written by the Health Maintenance Organization.

(2) For the purpose of determining the yearly deposit required under Section 27-21A-12, an HMO may report as covered expenditures any health care expenses which are covered under one or more of the following accepted methods:

(a) Reinsurance Contracts -- Expenditures may be covered by valid reinsurance contracts with solvent, authorized reinsurers under approved reinsurance contracts. The reinsurance contracts must provide which payments will be made to unaffiliated providers for services rendered for the duration of the contract period for which payment has been made after insolvency. The enrollees will have their coverages continued for at least the period of time for which their premiums have been paid, which the plan's benefits will be continued for enrollees who are confined in an acute care hospital or skilled nursing facility until their discharge, and which the reinsurer will make available to all enrollees for a period of thirty-one (31) days after the date of insolvency without evidence of insurability, a replacement health conversion insurance coverage of the same benefit schedule and rates as it is then offering to other prospective insureds within Alabama.

(b) Guarantees -- The estimated cost of health care services which are guaranteed, insured, or assumed by a solvent person having sufficient admissible assets, of equal quality and diversity as required of a newly licensed domestic life insurance company,

may be considered by the Commissioner to be covered if the guarantee is written, contractually binding on the person to be bound, the person is qualified to do business in Alabama, and the guaranteeing person is other than the health maintenance organization. The guarantee must state which the capital of the HMO will be maintained without impairment. However, unregulated guarantors (not regulated by an insurance department) must have an adjusted net worth (net worth = total assets less total liabilities less intangible assets less organization-related land, buildings, and equipment property minus lines of credit minus guarantees) of at least $5 million. Annual audited financial statements shall be required to be submitted by all guaranteeing persons.

(c) Hold-Harmless Clauses -- Expenditures may also be covered by approved "hold-harmless" clauses in provider contracts. All contracts for health care services shall contain a provision which providers shall hold the enrollee harmless for the payment of the cost of health care services in any event including, but not limited to, nonpayment of the health maintenance organization, or the health maintenance organization's insolvency. Generally, contracts meeting the approval of the State Health Officer shall satisfy the requirements of this subsection as being acceptable to the Commissioner. But in no case shall the HMO's capital account be impaired without the consideration of the expenditures as covered by this method. No HMO shall use this method to avoid the establishment of adequate reserves and rates (schedule of charges) to fund health care and overhead expenses.

Pre-insolvency and post-insolvency expenditures must be covered by at least one or more approved methods. In no case may other than health care expenses be considered as covered by any of these methods in this subsection.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-21A-19 and 27-2-17
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482-1-080-.06 Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-21A-19 and 27-2-17
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