

**TITLE 365. INSURANCE DEPARTMENT
CHAPTER 40. HEALTH MAINTENANCE ORGANIZATIONS (HMO)**

**SUBCHAPTER 5. LIFE, ACCIDENT & HEALTH DIVISION AND CONSUMER
ASSISTANCE AND CLAIMS DIVISION RULES**

PART 9. HMO REQUIREMENTS AND PROHIBITIONS

365:40-5-43. Premiums/co-payments

(a) Each HMO shall provide or arrange basic health care services for a basic health care services payment which:

- (1) Is paid on a periodic basis without regard to the dates these services are provided;
- (2) Is fixed without regard to the frequency, extent, or kind of basic health care services furnished;
- (3) Is fixed under a rating system which generates funds sufficient to meet the HMO's financial plan, and under which the rates are reasonable for the health services provided; and
- (4) May be supplemented by nominal co-payments for specific basic health care services. Each HMO may establish one or more co-payment options calculated on the basis of a rating system.

(A) An HMO may not impose co-payment charges that exceed fifty (50) percent of the total cost of providing any single service to its enrollees, or in the aggregate more than: ~~twenty (20) percent of the total cost of providing all basic health care services.~~

(i) forty-five (45) percent of the total cost of providing all basic health care services; or

(ii) the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) An HMO shall not impose on any subscriber or enrollee, in any calendar year, co-payment charges of more than two hundred (200) percent of the annual premium charged for an option with no co-payments.

(C) Co-payments applied to a service must be equal for all providers unless the unequal co-payments are based on differences in the cost to the HMO for the service.

(b) Basic health care services shall be provided for an illness or injury covered under a workers' compensation law or an insurance policy. The HMO may charge or authorize the provider to charge:

- (1) The insurance carrier, employer, or other entity which is required to pay for the services; and
- (2) The enrollee, to the extent that the enrollee has been paid under the law or policy for the services.

(c) An HMO may require payments for supplemental health care services in addition to the payments for basic health care services. Or, an HMO may include supplemental health care services in the basic health care services for a basic health care service payment.

(1) Supplemental health services payments may be made in any agreed upon manner, such as prepayment or fee-forservice.

(2) Supplemental health services may be limited as to time and cost.

(d) The Commissioner has discretion to approve a cost-sharing arrangement which does not satisfy the limitations imposed by this subsection if the Commissioner finds that such cost-sharing arrangement will provide a reduction in premium costs.