

**SUBSTITUTE FOR
HOUSE BILL NO. 5575**

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending sections 102, 224, 240, and 2213 (MCL 500.102,
500.224, 500.240, and 500.2213), section 224 as amended by 1998
PA 121, section 240 as amended by 1987 PA 261, and section 2213
as added by 1996 PA 517, and by adding chapter 35; and to repeal
acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 102. (1) "Commissioner" as used in this ~~code~~ ACT
2 means the commissioner of ~~insurance of this state~~ THE OFFICE OF
3 FINANCIAL AND INSURANCE SERVICES.

4 (2) "Department" as used in this ~~code~~ ACT means the
5 ~~insurance department of this state~~ OFFICE OF FINANCIAL AND
6 INSURANCE SERVICES.

1 Sec. 224. (1) All actual and necessary expenses incurred in
2 connection with the examination or other investigation of an
3 insurer or other person regulated under the commissioner's
4 authority shall be certified by the commissioner, together with a
5 statement of the work performed including the number of days
6 spent by the commissioner and each of the commissioner's depu-
7 ties, assistants, employees, and others acting under the
8 commissioner's authority. If correct, the expenses shall be paid
9 to the persons by whom they were incurred, upon the warrant of
10 the state treasurer payable from appropriations made by the leg-
11 islature for this purpose.

12 (2) Except as otherwise provided in subsection (4), the com-
13 missioner shall prepare and present to the insurer or other
14 person examined or investigated a statement of the expenses and
15 reasonable cost incurred for each person engaged upon the exami-
16 nation or investigation, including amounts necessary to cover the
17 pay and allowances granted to the persons by the Michigan civil
18 service commission, and the administration and supervisory
19 expense including an amount necessary to cover fringe benefits in
20 conjunction with the examination or investigation. Except as
21 otherwise provided in subsection (4), the insurer or other
22 person, upon receiving the statement, shall pay to the commis-
23 sioner the stated amount. The commissioner shall deposit the
24 funds with the state treasurer as provided in section 225.

25 (3) The commissioner may employ attorneys, actuaries,
26 accountants, investment advisers, and other expert personnel not
27 otherwise employees of this state reasonably necessary to assist

1 in the conduct of the examination or investigation or proceeding
2 with respect to an insurer or other person regulated under the
3 commissioner's authority at the insurer's or other person's
4 expense except as otherwise provided in subsection (4). Except
5 as otherwise provided in subsection (4), upon certification by
6 the commissioner of the reasonable expenses incurred under this
7 section, the insurer or other person examined or investigated
8 shall pay those expenses directly to the person or firm rendering
9 assistance to the commissioner. Expenses paid directly to such
10 person or firm and the regulatory fees imposed by this section
11 shall be examination expenses under section 22e of the single
12 business tax act, 1975 PA 228, MCL 208.22e.

13 (4) An insurer is subject to a regulatory fee instead of the
14 costs and expenses provided for in subsections (2) and (3). By
15 June 30 of each year or within 30 days after the enactment into
16 law of any appropriation for the insurance bureau's operation,
17 the commissioner shall impose upon all insurers authorized to do
18 business in this state a regulatory fee calculated as follows:

19 (a) As used in this subsection:

20 (i) "A" means total annuity considerations written in this
21 state in the immediately preceding year.

22 (ii) "B" means base assessment rate. The base assessment
23 rate shall not exceed .00038 and shall be a fraction the numera-
24 tor of which is the total regulatory fee and the denominator of
25 which is the total amount of direct underwritten premiums written
26 in this state by all insurers for the immediately preceding

1 calendar year as reported to the commissioner on the insurer's
2 annual statements filed with the commissioner.

3 (iii) "I" means all direct underwritten premiums other than
4 life insurance premiums and annuity considerations written in
5 this state in the immediately preceding year by all insurers.

6 (iv) "L" means all direct underwritten life insurance premi-
7 ums written in this state in the immediately preceding year by
8 all life insurers.

9 (v) Total regulatory fee shall not exceed 80% of the gross
10 appropriations for the insurance bureau's operation for a fiscal
11 year and shall be the difference between the gross appropriations
12 for the insurance bureau's operation for that current fiscal year
13 and any restricted revenues, other than the regulatory fee
14 itself, as identified in the gross appropriation for the insur-
15 ance bureau's operation.

16 (vi) Direct premiums written in this state do not include
17 any amounts that represent claims payments that are made on
18 behalf of, or administrative fees that are paid in connection
19 with, any administrative service contract, cost-plus arrangement,
20 or any other noninsured or self-insured business.

21 (b) Two actual assessment rates shall be calculated so as to
22 distribute 75% of the burden of the regulatory fee shortfall cre-
23 ated by the exclusion of annuity considerations from the assess-
24 ment base to life insurance and 25% to all other insurance. The
25 2 actual assessment rates shall be determined as follows:

26 (i)
$$\frac{L \times B + .75 \times B \times A}{L} = \text{assessment rate for life}$$

27 insurance.

1 (6) The amount, if any, by which amounts credited to the
2 commissioner pursuant to section 225 exceed actual expenditures
3 pursuant to appropriations for the insurance bureau's operation
4 for a fiscal year shall be credited toward the appropriation for
5 the insurance bureau in the next fiscal year.

6 (7) All money paid into the state treasury by an insurer
7 under this section shall be credited as provided under section
8 225.

9 (8) A regulatory fee under this section shall not be treated
10 by an insurer as a levy or excise upon premium but as a regula-
11 tory burden that is apportioned in relation to insurance activity
12 in this state and reflects the insurance regulatory burden on
13 this state as a result of this insurance activity. A foreign or
14 alien insurer authorized to do business in this state may con-
15 sider the liability required under this section as a burden
16 imposed by the state of Michigan in the calculation of the
17 insurer's liability required under section 476a.

18 (9) An insurer may file with the commissioner a protest to
19 the regulatory fee imposed not later than 15 days after receipt
20 of the regulatory fee. The commissioner shall review the grounds
21 for the protest and shall hold a conference with the insurer at
22 the insurer's request. The commissioner shall transmit his or
23 her findings to the insurer with a restatement of the regulatory
24 fee based upon the findings. Statements of regulatory fees to
25 which protests have not been made and restatements of regulatory
26 fees are due and shall be paid not later than 30 days after their
27 receipt. Regulatory fees that are not paid when due bear

1 interest on the unpaid fee which shall be calculated at 6-month
2 intervals from the date the fee was due at a rate of interest
3 equal to 1% plus the average interest rate paid at auctions of
4 5-year United States treasury notes during the 6 months immedi-
5 ately preceding July 1 and January 1, as certified by the state
6 treasurer, and compounded annually, until the assessment is paid
7 in full. An insurer who fails to pay its regulatory fee within
8 the prescribed time limits may have its certificate of authority
9 or license suspended, limited, or revoked as the commissioner
10 considers warranted until the regulatory fee is paid. If the
11 commissioner determines that a regulatory fee or a part of a
12 regulatory fee paid by an insurer is in excess of the amount
13 legally due and payable, the amount of the excess shall be
14 refunded or, at the insurer's option, be applied as a credit
15 against the regulatory fee for the next fiscal year. An overpay-
16 ment of \$100.00 or less shall be applied as a credit against the
17 insurer's regulatory fee for the next fiscal year unless the
18 insurer had a \$100.00 or less overpayment in the immediately pre-
19 ceding fiscal year. If the insurer had a \$100.00 or less over-
20 payment in the immediately preceding fiscal year, at the
21 insurer's option, the current fiscal year overpayment of \$100.00
22 or less shall be refunded.

23 (10) Any amounts stated and presented to or certified,
24 assessed, or imposed upon an insurer as provided in
25 subsections (2), (3), and (4) that are unpaid as of the date that
26 the insurer is subjected to a delinquency proceeding pursuant to
27 chapter 81 shall be regarded as an expense of administering the

1 delinquency proceeding and shall be payable as such from the
2 general assets of the insurer.

3 ~~-(11) Any statements presented to insurers pursuant to sub-~~
4 ~~sections (2) and (3) for examinations or investigations conducted~~
5 ~~since October 1, 1993 shall be cancelled as of June 30, 1994.~~
6 ~~Amounts actually paid by an insurer because of those statements~~
7 ~~shall be credited against the regulatory fee levied for the~~
8 ~~1993-94 fiscal year and any excess amounts shall be refunded.~~

9 (11) ~~-(12)~~ In addition to the regulatory fee provided in
10 subsection (4), each insurer that locates records or personnel
11 knowledgeable about those records outside this state pursuant to
12 section 476a(3) or section 5256 shall reimburse the insurance
13 bureau for expenses and reasonable costs incurred by the insur-
14 ance bureau as a result of travel and other costs related to
15 examinations or investigations of those records or personnel.
16 The reimbursement shall not include any costs that the insurance
17 bureau would have incurred if the examination had taken place in
18 this state.

19 (12) ~~-(13)~~ As used in this section:

20 (a) "Annuity considerations" means receipts on the sale of
21 annuities as used in section 22a of the single business tax act,
22 1975 PA 228, MCL 208.22a.

23 (b) "Insurer" means an insurer authorized to do business in
24 this state and includes nonprofit health care corporations,
25 dental care corporations, and health maintenance organizations.

26 (13) ~~-(14)~~ All fees added by ~~the amendatory act that added~~
27 ~~this subsection~~ 1994 PA 228 shall not apply on and after

1 January 1, 1996, unless by September 1, 1995, and annually
2 thereafter, the commissioner submits a report to the senate and
3 house of representatives standing committees on insurance issues
4 and to the senate and house of representatives appropriations
5 regulatory subcommittees on all receivership activities of the
6 commissioner and the insurance bureau pertaining to the liquida-
7 tion of insolvent insurers for the immediately preceding calendar
8 year. The report shall include all of the following:

9 (a) A summary schedule of all insurance bureau expenditures
10 for legal, accounting, and administrative expenditures made or
11 incurred for the liquidation of all insurers in receivership,
12 including, but not limited to, alien insurers described in
13 section 431a, and paid for out of the insurer's assets during the
14 calendar year being reported on.

15 (b) A detailed schedule of all insurance bureau contractual
16 expenditures for legal, accounting, and administrative expendi-
17 tures made or incurred for the liquidation of all insurers in
18 receivership, including, but not limited to, alien insurers
19 described in section 431a, and paid for out of the insurer's
20 assets during the calendar year being reported on including, but
21 not limited to, itemization of legal billings, criminal investi-
22 gation expenses, travel, meals, and general office expenses.

23 (c) A statement of the net changes in assets and liabilities
24 of each insurer in receivership, including, but not limited to,
25 an alien insurer described in section 431a. This statement shall
26 include changes due to interest rate changes, real estate values,
27 and other investment activities, including a detailed statement

1 of the sale of assets and the net loss or gain on those assets
2 and a statement of the amount of assets preserved, gained, or
3 recovered by the receiver.

4 Sec. 240. (1) The commissioner shall collect, and the
5 person affected shall pay to the commissioner, the following
6 fees:

- 7 (a) Filing fee for original authorization to
8 transact insurance OR HEALTH MAINTENANCE ORGANIZATION
9 BUSINESS in this state, for each domestic, ~~insurer,~~
10 ~~and each~~ foreign, and alien insurer, AND EACH HEALTH
11 MAINTENANCE ORGANIZATION..... \$ 25.00.
- 12 (b) Filing fee for annual statement of foreign and
13 alien insurers, each year, subject to section 476a.... \$ 25.00.
- 14 (c) Agent's appointment fee, resident or nonresi-
15 dent, payable by insurer OR HEALTH MAINTENANCE
16 ORGANIZATION so represented, for each agent, each year. \$ 5.00.
- 17 (d) Application fee payable by each initial appli-
18 cant for license as resident agent, nonresident agent,
19 surplus lines agent, solicitor, counselor, or adjuster,
20 not transferable or refundable..... \$ 10.00.
- 21 (e) Solicitor's license, each year..... \$ 10.00.
- 22 (f) Insurance counselor license, each year..... \$ 10.00.
- 23 (g) Adjuster's license, each year..... \$ 5.00.
- 24 (h) License examination fee, payable by applicant
25 for all subjects covered in any 1 examination, or por-
26 tion of an examination, for license as resident agent,

1 surplus lines agent, solicitor, counselor, or adjuster,
2 each examination, not transferable or refundable..... \$ 10.00.

3 (i) Surplus lines agent license each year..... \$100.00.

4 ~~(j) Certification of records..... \$ 2.00.~~

5 (2) Each incorporated domestic insurer shall pay to the
6 attorney general, for the examination of the insurer's articles
7 of incorporation or any amendments to the articles of incorpora-
8 tion, the sum of \$25.00.

9 (3) The fees and charges for official services performed by
10 the commissioner or the commissioner's deputies or employees,
11 when collected, shall be turned over to the state treasurer and a
12 receipt taken. The fees and charges provided for in this section
13 shall be deposited in the state treasury to the credit of the
14 general fund.

15 (4) The provisions of subsection (1)(h), insofar as they
16 provide for examination fees, are applicable only if the examina-
17 tions are administered by the commissioner. If the examinations
18 are administered by some designated authority other than the com-
19 missioner, appropriate examination fees shall be payable directly
20 to the designated authority.

21 Sec. 2213. (1) ~~By October 1, 1997, an~~ EACH insurer AND
22 HEALTH MAINTENANCE ORGANIZATION shall establish an internal
23 formal grievance procedure for approval by the ~~insurance bureau~~
24 COMMISSIONER for persons covered under a policy, ~~or~~
25 certificate, OR CONTRACT issued under chapter 34, 35, or 36 that
26 includes all of the following:

1 (a) Provides for a designated person responsible for
2 administering the grievance system.

3 (b) Provides a designated person or telephone number for
4 receiving complaints.

5 (c) Ensures full investigation of a complaint.

6 (d) Provides for timely notification IN PLAIN ENGLISH to the
7 insured OR ENROLLEE as to the progress of an investigation.

8 (e) Provides an insured OR ENROLLEE the right to appear
9 before the board of directors or designated committee or the
10 right to a managerial-level conference to present a grievance.

11 (f) Provides for notification IN PLAIN ENGLISH to the
12 insured OR ENROLLEE of the results of the insurer's OR HEALTH
13 MAINTENANCE ORGANIZATION'S investigation and for advisement of
14 the insured's OR ENROLLEE'S right to review the grievance by the
15 commissioner THROUGH SEPTEMBER 30, 2000 AND BEGINNING OCTOBER 1,
16 2000 BY AN INDEPENDENT REVIEW ORGANIZATION UNDER THE PATIENT'S
17 RIGHT TO INDEPENDENT REVIEW ACT.

18 (g) Provides summary data on the number and types of com-
19 plaints AND GRIEVANCES filed. BEGINNING APRIL 15, 2001, THIS
20 SUMMARY DATA FOR THE PRIOR CALENDAR YEAR SHALL BE FILED ANNUALLY
21 WITH THE COMMISSIONER ON FORMS PROVIDED BY THE COMMISSIONER.

22 (h) Provides for periodic management and governing body
23 review of the data to assure that appropriate actions have been
24 taken.

25 (i) Provides for copies of all complaints and responses to
26 be available at the principal office of the insurer OR HEALTH
27 MAINTENANCE ORGANIZATION for inspection by the ~~insurance bureau~~

1 COMMISSIONER for 2 years following the year the complaint was
2 filed.

3 (j) That when an adverse determination is made, a written
4 statement IN PLAIN ENGLISH containing the reasons for the adverse
5 determination ~~will be~~ IS provided to the insured ~~person.~~ (k)
6 ~~That a~~ OR ENROLLEE ALONG WITH written ~~notification of the~~
7 ~~grievance procedures will be provided to the insured person when~~
8 ~~the insured person contests an adverse determination~~
9 NOTIFICATIONS AS REQUIRED UNDER THE PATIENT'S RIGHT TO INDEPEN-
10 DENT REVIEW ACT.

11 (K) ~~(I)~~ That a final determination will be made in writing
12 by the insurer OR HEALTH MAINTENANCE ORGANIZATION not later than
13 ~~90~~ [25] calendar days after a formal grievance is submitted in
14 writing by the insured ~~person~~ OR ENROLLEE. The timing for the
15 ~~90-calendar-day~~ [25-CALENDAR-DAY] period may be tolled, however,
16 for any period of time the insured ~~person~~ OR ENROLLEE is per-
17 mitted to take under the grievance procedure [AND FOR A PERIOD OF
TIME THAT SHALL NOT EXCEED 5 DAYS IF THE INSURER OR HEALTH
MAINTENANCE ORGANIZATION HAS NOT RECEIVED REQUESTED INFORMATION FROM
A HEALTH CARE FACILITY OR HEALTH PROFESSIONAL].

18 (l) ~~(m)~~ That ~~an initial~~ A determination will be made by
19 the insurer OR HEALTH MAINTENANCE ORGANIZATION not later than 72
20 hours after receipt of an expedited grievance. ~~Within~~
21 ~~3 business days after the initial determination by the insurer,~~
22 ~~the insured or a person, including, but not limited to, a physi-~~
23 ~~cian, authorized in writing to act on behalf of the insured may~~
24 ~~request further review by the insurer or for a determination of~~
25 ~~the matter by the commissioner or his or her designee. If fur-~~
26 ~~ther review is requested, a final determination by the insurer~~
27 ~~shall be made not later than 30 days after receipt of the request~~

1 ~~for further review.~~ Within 10 days after receipt of a ~~final~~
2 determination, the insured or ~~a person, including, but not~~
3 ~~limited to, a physician, authorized in writing to act on behalf~~
4 ~~of the insured~~ ENROLLEE may request a determination of the
5 matter by the commissioner or his or her designee THROUGH
6 SEPTEMBER 30, 2000 AND BEGINNING OCTOBER 1, 2000 BY AN INDEPEN-
7 DENT REVIEW ORGANIZATION UNDER THE PATIENT'S RIGHT TO INDEPENDENT
8 REVIEW ACT. If the ~~initial or final~~ determination by the
9 insurer OR HEALTH MAINTENANCE ORGANIZATION is made orally, the
10 insurer OR HEALTH MAINTENANCE ORGANIZATION shall provide a writ-
11 ten confirmation of the determination to the insured OR ENROLLEE
12 not later than 2 business days after the oral determination. An
13 expedited grievance under this subdivision applies if a grievance
14 is submitted and a physician, orally or in writing, substantiates
15 that the time frame for a grievance under subdivision ~~(t)~~ (K)
16 would ~~acutely~~ SERIOUSLY jeopardize the life OR HEALTH of the
17 insured OR ENROLLEE OR WOULD JEOPARDIZE THE INSURED'S OR
18 ENROLLEE'S ABILITY TO REGAIN MAXIMUM FUNCTION.

19 (M) ~~(n)~~ That the insured ~~person~~ OR ENROLLEE has the
20 right to a determination of the matter by the commissioner or his
21 or her designee THROUGH SEPTEMBER 30, 2000 AND BEGINNING OCTOBER
22 1, 2000 BY AN INDEPENDENT REVIEW ORGANIZATION UNDER THE PATIENT'S
23 RIGHT TO INDEPENDENT REVIEW ACT.

24 ~~(2) The commissioner shall establish a procedure for a~~
25 ~~determination of a grievance under this section which shall be~~
26 ~~reasonably calculated to resolve these matters informally and as~~
27 ~~rapidly as possible, while protecting the interests of both the~~

~~1 insured and the insurer. This procedure is not a contested case
2 under the administrative procedures act of 1969, Act No. 306 of
3 the Public Acts of 1969, being sections 24.201 to 24.328 of the
4 Michigan Compiled Laws, and is not appealable under Act No. 306
5 of the Public Acts of 1969.~~

6 (2) AN INSURED OR ENROLLEE MAY AUTHORIZE IN WRITING ANY
7 PERSON, INCLUDING, BUT NOT LIMITED TO, A PHYSICIAN, TO ACT ON HIS
8 OR HER BEHALF AT ANY STAGE IN A GRIEVANCE PROCEEDING UNDER THIS
9 SECTION.

10 (3) This section does not apply to a provider's complaint
11 concerning claims payment, handling, or reimbursement for health
12 care services.

13 (4) As used in this section:

14 (a) "Adverse determination" means a determination that an
15 admission, availability of care, continued stay, or other health
16 care service has been reviewed and denied, REDUCED, OR
17 TERMINATED. Failure to respond in a timely manner to a request
18 for a determination constitutes an adverse determination.

19 (b) "Grievance" means a complaint on behalf of an insured
20 ~~person~~ OR ENROLLEE submitted by an insured ~~person or a person,~~
21 ~~including, but not limited to, a physician, authorized in writing~~
22 ~~to act on behalf of the insured person regarding~~ OR ENROLLEE
23 CONCERNING ANY OF THE FOLLOWING:

24 (i) The availability, delivery, or quality of health care
25 services, including a complaint regarding an adverse determina-
26 tion made pursuant to utilization review.

1 (ii) Benefits or claims payment, handling, or reimbursement
2 for health care services.

3 (iii) Matters pertaining to the contractual relationship
4 between an insured OR ENROLLEE and the insurer OR HEALTH MAINTENANCE ORGANIZATION.
5

6 CHAPTER 35

7 HEALTH MAINTENANCE ORGANIZATIONS

8 SEC. 3501. AS USED IN THIS CHAPTER:

9 (A) "AFFILIATED PROVIDER" MEANS A HEALTH PROFESSIONAL,
10 LICENSED HOSPITAL, LICENSED PHARMACY, OR ANY OTHER INSTITUTION,
11 ORGANIZATION, OR PERSON HAVING A CONTRACT WITH A HEALTH MAINTENANCE ORGANIZATION TO RENDER 1 OR MORE HEALTH MAINTENANCE SERVICES TO AN ENROLLEE.
12
13

14 (B) "BASIC HEALTH SERVICES" MEANS:

15 (i) PHYSICIAN SERVICES INCLUDING CONSULTANT AND REFERRAL
16 SERVICES BY A PHYSICIAN, BUT NOT INCLUDING PSYCHIATRIC SERVICES.

17 (ii) AMBULATORY SERVICES.

18 (iii) INPATIENT HOSPITAL SERVICES, OTHER THAN THOSE FOR THE
19 TREATMENT OF ILLNESS.

20 (iv) EMERGENCY HEALTH SERVICES.

21 (v) OUTPATIENT MENTAL HEALTH SERVICES, NOT FEWER THAN 20
22 VISITS PER YEAR.

23 (vi) INTERMEDIATE AND OUTPATIENT CARE FOR SUBSTANCE ABUSE AS
24 FOLLOWS:

25 (A) FOR GROUP CONTRACTS, IF THE FEES FOR A GROUP CONTRACT
26 WOULD BE INCREASED BY 3% OR MORE BECAUSE OF THE PROVISION OF
27 SERVICES UNDER THIS SUBPARAGRAPH, THE GROUP SUBSCRIBER MAY

1 DECLINE THE SERVICES. FOR INDIVIDUAL CONTRACTS, IF THE TOTAL
2 FEES FOR ALL INDIVIDUAL CONTRACTS WOULD BE INCREASED BY 3% OR
3 MORE BECAUSE OF THE PROVISION OF THE SERVICES REQUIRED UNDER THIS
4 SUBPARAGRAPH IN ALL OF THOSE CONTRACTS, THE NAMED SUBSCRIBER OF
5 EACH CONTRACT MAY DECLINE THE SERVICES.

6 (B) CHARGES, TERMS, AND CONDITIONS FOR THE SERVICES REQUIRED
7 TO BE PROVIDED UNDER THIS SUBPARAGRAPH SHALL NOT BE LESS FAVOR-
8 ABLE THAN THE MAXIMUM PRESCRIBED FOR ANY OTHER COMPARABLE
9 SERVICE.

10 (C) THE SERVICES REQUIRED TO BE PROVIDED UNDER THIS SUBPARA-
11 GRAPH SHALL NOT BE REDUCED BY TERMS OR CONDITIONS THAT APPLY TO
12 OTHER SERVICES IN A GROUP OR INDIVIDUAL CONTRACT. THIS
13 SUB-SUBPARAGRAPH SHALL NOT BE CONSTRUED TO PROHIBIT CONTRACTS
14 THAT PROVIDE FOR DEDUCTIBLES AND COPAYMENT PROVISIONS FOR SERV-
15 ICES FOR INTERMEDIATE AND OUTPATIENT CARE FOR SUBSTANCE ABUSE.

16 (D) THE SERVICES REQUIRED TO BE PROVIDED UNDER THIS SUBPARA-
17 GRAPH SHALL, AT A MINIMUM, PROVIDE FOR UP TO \$2,968.00 IN SERV-
18 ICES FOR INTERMEDIATE AND OUTPATIENT CARE FOR SUBSTANCE ABUSE PER
19 INDIVIDUAL PER YEAR. THIS MINIMUM SHALL BE ADJUSTED ANNUALLY BY
20 MARCH 31 EACH YEAR IN ACCORDANCE WITH THE ANNUAL AVERAGE PERCEN-
21 TAGE INCREASE OR DECREASE IN THE UNITED STATES CONSUMER PRICE
22 INDEX FOR THE 12-MONTH PERIOD ENDING THE PRECEDING DECEMBER 31.

23 (E) AS USED IN THIS SUBPARAGRAPH, "INTERMEDIATE CARE",
24 "OUTPATIENT CARE", AND "SUBSTANCE ABUSE" HAVE THOSE MEANINGS
25 ASCRIBED TO THEM IN SECTION 3425.

26 (vii) DIAGNOSTIC LABORATORY AND DIAGNOSTIC AND THERAPEUTIC
27 RADIOLOGICAL SERVICES.

1 (viii) HOME HEALTH SERVICES.

2 (ix) PREVENTIVE HEALTH SERVICES.

3 (C) "CREDENTIALING VERIFICATION" MEANS THE PROCESS OF
4 OBTAINING AND VERIFYING INFORMATION ABOUT A HEALTH PROFESSIONAL
5 AND EVALUATING THAT HEALTH PROFESSIONAL WHEN THAT HEALTH PROFES-
6 SIONAL APPLIES TO BECOME A PARTICIPATING PROVIDER WITH A HEALTH
7 MAINTENANCE ORGANIZATION.

8 (D) "ENROLLEE" MEANS AN INDIVIDUAL WHO IS ENTITLED TO
9 RECEIVE HEALTH MAINTENANCE SERVICES UNDER A HEALTH MAINTENANCE
10 CONTRACT.

11 (E) "HEALTH MAINTENANCE CONTRACT" MEANS A CONTRACT BETWEEN A
12 HEALTH MAINTENANCE ORGANIZATION AND A SUBSCRIBER OR GROUP OF SUB-
13 SCRIBERS, TO PROVIDE, WHEN MEDICALLY INDICATED, DESIGNATED HEALTH
14 MAINTENANCE SERVICES, AS DESCRIBED IN AND PURSUANT TO THE TERMS
15 OF THE CONTRACT, INCLUDING, AT A MINIMUM, BASIC HEALTH MAINTENANCE
16 SERVICES. HEALTH MAINTENANCE CONTRACT INCLUDES A PRUDENT
17 PURCHASER CONTRACT.

18 (F) "HEALTH MAINTENANCE ORGANIZATION" MEANS AN ENTITY THAT
19 DOES THE FOLLOWING:

20 (i) DELIVERS HEALTH MAINTENANCE SERVICES THAT ARE MEDICALLY
21 INDICATED TO ENROLLEES UNDER THE TERMS OF ITS HEALTH MAINTENANCE
22 CONTRACT, DIRECTLY OR THROUGH CONTRACTS WITH AFFILIATED PROVID-
23 ERS, IN EXCHANGE FOR A FIXED PREPAID SUM OR PER CAPITA PREPAY-
24 MENT, WITHOUT REGARD TO THE FREQUENCY, EXTENT, OR KIND OF HEALTH
25 SERVICES.

26 (ii) IS RESPONSIBLE FOR THE AVAILABILITY, ACCESSIBILITY, AND
27 QUALITY OF THE HEALTH MAINTENANCE SERVICES PROVIDED.

1 (G) "HEALTH MAINTENANCE SERVICES" MEANS SERVICES PROVIDED TO
2 ENROLLEES OF A HEALTH MAINTENANCE ORGANIZATION UNDER THEIR HEALTH
3 MAINTENANCE CONTRACT.

4 (H) "HEALTH PROFESSIONAL" MEANS AN INDIVIDUAL LICENSED, CER-
5 TIFIED, OR AUTHORIZED IN ACCORDANCE WITH STATE LAW TO PRACTICE A
6 HEALTH PROFESSION IN HIS OR HER RESPECTIVE STATE.

7 (I) "PRIMARY VERIFICATION" MEANS VERIFICATION BY THE HEALTH
8 MAINTENANCE ORGANIZATION OF A HEALTH PROFESSIONAL'S CREDENTIALS
9 BASED UPON EVIDENCE OBTAINED FROM THE ISSUING SOURCE OF THE
10 CREDENTIAL.

11 (J) "PRUDENT PURCHASER CONTRACT" MEANS A CONTRACT OFFERED BY
12 A HEALTH MAINTENANCE ORGANIZATION TO GROUPS OR TO INDIVIDUALS
13 UNDER WHICH ENROLLEES WHO SELECT TO OBTAIN HEALTH CARE SERVICES
14 DIRECTLY FROM THE ORGANIZATION OR THROUGH ITS AFFILIATED PROVID-
15 ERS RECEIVE A FINANCIAL ADVANTAGE OR OTHER ADVANTAGE BY SELECTING
16 THOSE PROVIDERS.

17 (K) "SECONDARY VERIFICATION" MEANS VERIFICATION BY THE
18 HEALTH MAINTENANCE ORGANIZATION OF A HEALTH PROFESSIONAL'S CRE-
19 DENTIALS BASED UPON EVIDENCE OBTAINED BY MEANS OTHER THAN DIRECT
20 CONTACT WITH THE ISSUING SOURCE OF THE CREDENTIAL.

21 (L) "SERVICE AREA" MEANS A DEFINED GEOGRAPHICAL AREA IN
22 WHICH HEALTH MAINTENANCE SERVICES ARE GENERALLY AVAILABLE AND
23 READILY ACCESSIBLE TO ENROLLEES AND WHERE HEALTH MAINTENANCE
24 ORGANIZATIONS MAY MARKET THEIR CONTRACTS.

25 (M) "SUBSCRIBER" MEANS AN INDIVIDUAL WHO ENTERS INTO A
26 HEALTH MAINTENANCE CONTRACT, OR ON WHOSE BEHALF A HEALTH
27 MAINTENANCE CONTRACT IS ENTERED INTO, WITH A HEALTH MAINTENANCE

1 ORGANIZATION THAT HAS RECEIVED A CERTIFICATE OF AUTHORITY UNDER
2 THIS CHAPTER AND TO WHOM A HEALTH MAINTENANCE CONTRACT IS
3 ISSUED.

4 SEC. 3503. (1) ALL OF THE PROVISIONS OF THIS ACT THAT APPLY
5 TO A DOMESTIC INSURER AUTHORIZED TO ISSUE AN EXPENSE-INCURRED
6 HOSPITAL, MEDICAL, OR SURGICAL POLICY OR CERTIFICATE, INCLUDING,
7 BUT NOT LIMITED TO, SECTION 223 AND CHAPTERS 34 AND 36, APPLY TO
8 A HEALTH MAINTENANCE ORGANIZATION UNDER THIS CHAPTER UNLESS SPE-
9 CIFICALLY EXCLUDED, OR OTHERWISE SPECIFICALLY PROVIDED FOR IN
10 THIS CHAPTER.

11 (2) SECTIONS 408, 410, 411, 901, AND 5208 AND CHAPTERS 77
12 AND 79 DO NOT APPLY TO A HEALTH MAINTENANCE ORGANIZATION.

13 SEC. 3505. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL
14 RECEIVE A CERTIFICATE OF AUTHORITY UNDER THIS CHAPTER BEFORE
15 ISSUING HEALTH MAINTENANCE CONTRACTS. A HEALTH MAINTENANCE
16 ORGANIZATION LICENSE ISSUED UNDER FORMER PART 210 OF THE PUBLIC
17 HEALTH CODE, 1978 PA 368, AUTOMATICALLY BECOMES A CERTIFICATE OF
18 AUTHORITY UNDER THIS CHAPTER ON THE EFFECTIVE DATE OF THIS
19 CHAPTER.

20 (2) "HEALTH MAINTENANCE ORGANIZATION" SHALL NOT BE USED TO
21 DESCRIBE OR REFER TO ANY ENTITY OR PERSON AND AN ENTITY OR PERSON
22 SHALL NOT USE ANY OTHER DESCRIPTIVE WORDS THAT MAY MISLEAD,
23 DECEIVE, OR IMPLY THAT IT IS A HEALTH MAINTENANCE ORGANIZATION,
24 UNLESS THE ENTITY OR PERSON HAS A CERTIFICATE OF AUTHORITY AS A
25 HEALTH MAINTENANCE ORGANIZATION UNDER THIS CHAPTER.

26 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL NOT USE IN ITS
27 NAME, CONTRACTS, OR LITERATURE THE WORDS "INSURANCE", "CASUALTY",

1 "SURETY", "MUTUAL", OR ANY OTHER WORDS DESCRIPTIVE OF AN
2 INSURANCE, CASUALTY, OR SURETY BUSINESS OR DECEPTIVELY SIMILAR TO
3 THE NAME OR DESCRIPTION OF AN INSURANCE OR SURETY CORPORATION
4 DOING BUSINESS IN THIS STATE.

5 SEC. 3507. THE COMMISSIONER SHALL ESTABLISH A SYSTEM OF
6 AUTHORIZING AND REGULATING HEALTH MAINTENANCE ORGANIZATIONS IN
7 THIS STATE TO PROTECT AND PROMOTE THE PUBLIC HEALTH THROUGH THE
8 ASSURANCE THAT THE ORGANIZATIONS PROVIDE:

9 (A) AN ACCEPTABLE QUALITY OF HEALTH CARE BY QUALIFIED
10 PERSONNEL.

11 (B) HEALTH CARE FACILITIES, EQUIPMENT, AND PERSONNEL THAT
12 MAY REASONABLY BE REQUIRED TO ECONOMICALLY PROVIDE HEALTH MAINTENANCE
13 SERVICES.

14 (C) OPERATIONAL ARRANGEMENTS THAT INTEGRATE THE DELIVERY OF
15 VARIOUS SERVICES.

16 (D) A FINANCIALLY SOUND PREPAYMENT PLAN FOR MEETING HEALTH
17 CARE COSTS.

18 SEC. 3508. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL
19 DEVELOP AND MAINTAIN A QUALITY ASSESSMENT PROGRAM TO ASSESS THE
20 QUALITY OF HEALTH CARE PROVIDED TO ENROLLEES THAT INCLUDES, AT A
21 MINIMUM, SYSTEMATIC COLLECTION, ANALYSIS, AND REPORTING OF RELEVANT
22 DATA IN ACCORDANCE WITH STATUTORY AND REGULATORY
23 REQUIREMENTS. A HEALTH MAINTENANCE ORGANIZATION SHALL MAKE
24 AVAILABLE ITS QUALITY ASSESSMENT PROGRAM AS PRESCRIBED BY THE
25 COMMISSIONER.

26 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL ESTABLISH AND
27 MAINTAIN A QUALITY IMPROVEMENT PROGRAM TO DESIGN, MEASURE,

1 ASSESS, AND IMPROVE THE PROCESSES AND OUTCOMES OF HEALTH CARE AS
2 IDENTIFIED IN THE PROGRAM. A HEALTH MAINTENANCE ORGANIZATION
3 SHALL MAKE AVAILABLE ITS QUALITY IMPROVEMENT PROGRAM AS PRE-
4 SCRIBED BY THE COMMISSIONER. THE QUALITY IMPROVEMENT PROGRAM
5 SHALL BE UNDER THE DIRECTION OF THE HEALTH MAINTENANCE
6 ORGANIZATION'S MEDICAL DIRECTOR AND SHALL INCLUDE:

7 (A) A WRITTEN STATEMENT OF THE PROGRAM'S OBJECTIVES, LINES
8 OF AUTHORITY AND ACCOUNTABILITY, EVALUATION TOOLS, INCLUDING DATA
9 COLLECTION RESPONSIBILITIES, AND PERFORMANCE IMPROVEMENT
10 ACTIVITIES.

11 (B) AN ANNUAL EFFECTIVENESS REVIEW OF THE PROGRAM.

12 (C) A WRITTEN QUALITY IMPROVEMENT PLAN THAT, AT A MINIMUM,
13 DESCRIBES HOW THE HEALTH MAINTENANCE ORGANIZATION ANALYZES BOTH
14 THE PROCESSES AND OUTCOMES OF CARE, IDENTIFIES THE TARGETED DIAG-
15 NOSES AND TREATMENTS TO BE REVIEWED EACH YEAR, USES A RANGE OF
16 APPROPRIATE METHODS TO ANALYZE QUALITY, COMPARES PROGRAM FINDINGS
17 WITH PAST PERFORMANCE AND INTERNAL GOALS AND EXTERNAL STANDARDS,
18 MEASURES THE PERFORMANCE OF AFFILIATED PROVIDERS, AND CONDUCTS
19 PEER REVIEW ACTIVITIES.

20 SEC. 3509. (1) AN APPLICATION TO THE COMMISSIONER FOR A
21 CERTIFICATE OF AUTHORITY SHALL BE ON A FORM PRESCRIBED AND PRO-
22 VIDED BY THE COMMISSIONER.

23 (2) A CERTIFICATE OF AUTHORITY ISSUED UNDER THIS CHAPTER IS
24 LIMITED TO THE SERVICE AREA DESCRIBED IN THE APPLICATION UPON
25 WHICH THE CERTIFICATE OF AUTHORITY WAS ISSUED.

26 (3) A HEALTH MAINTENANCE ORGANIZATION SEEKING TO CHANGE THE
27 APPROVED SERVICE AREA SHALL SUBMIT AN APPLICATION TO CHANGE

1 SERVICE AREA TO THE COMMISSIONER AND SHALL NOT CHANGE THE SERVICE
2 AREA UNTIL APPROVAL IS RECEIVED. THE COMMISSIONER SHALL SPECIFY
3 THE INFORMATION REQUIRED TO BE IN THE APPLICATION UNDER THIS
4 SUBSECTION.

5 SEC. 3511. (1) BY THE END OF THE FIRST 12 MONTHS OF OPERA-
6 TION, A HEALTH MAINTENANCE ORGANIZATION'S GOVERNING BODY SHALL
7 HAVE A MINIMUM OF 1/3 OF ITS MEMBERSHIP CONSISTING OF ADULT
8 ENROLLEES OF THE ORGANIZATION WHO ARE NOT COMPENSATED OFFICERS,
9 EMPLOYEES, STOCKHOLDERS WHO OWN MORE THAN 5% OF THE
10 ORGANIZATION'S SHARES, OR OTHER INDIVIDUALS RESPONSIBLE FOR THE
11 CONDUCT OF, OR FINANCIALLY INTERESTED IN, THE ORGANIZATION'S
12 AFFAIRS. THE ENROLLEE BOARD MEMBERS SHALL BE ELECTED BY A SIMPLE
13 PLURALITY OF THE VOTING SUBSCRIBERS. EACH SUBSCRIBER SHALL HAVE
14 1 VOTE. THE ENROLLEE BOARD MEMBERS SHALL HOLD OFFICE FOR 3 YEARS
15 AFTER THEIR ELECTION, EXCEPT THAT THE TERMS OF OFFICE FOLLOWING
16 THE FIRST ENROLLEE ELECTION MAY BE ADJUSTED TO ALLOW THE TERMS OF
17 ENROLLEE BOARD MEMBERS TO EXPIRE ON A STAGGERED BASIS. A VACANCY
18 AMONG ENROLLEE BOARD MEMBERS SHALL BE FILLED BY APPOINTMENT BY A
19 SIMPLE MAJORITY OF THE REMAINING ENROLLEE MEMBERS OF THE BOARD
20 FROM INDIVIDUALS MEETING THE QUALIFICATIONS OF THIS SECTION. A
21 VACANCY SHALL BE FILLED ONLY FOR THE UNEXPIRED PORTION OF THE
22 ORIGINAL TERM, AT WHICH TIME THE ENROLLEE MEMBER SHALL BE ELECTED
23 IN THE MANNER PRESCRIBED BY THIS CHAPTER.

24 (2) A HEALTH MAINTENANCE ORGANIZATION'S GOVERNING BODY SHALL
25 MEET AT LEAST QUARTERLY UNLESS SPECIFICALLY EXEMPTED FROM THIS
26 REQUIREMENT BY THE COMMISSIONER.

1 SEC. 3513. (1) THE COMMISSIONER SHALL REGULATE HEALTH
2 DELIVERY ASPECTS OF HEALTH MAINTENANCE ORGANIZATION OPERATIONS
3 FOR THE PURPOSE OF ASSURING THAT HEALTH MAINTENANCE ORGANIZATIONS
4 ARE CAPABLE OF PROVIDING CARE AND SERVICES PROMPTLY, APPROPRIATE-
5 LY, AND IN A MANNER THAT ASSURES CONTINUITY AND ACCEPTABLE QUAL-
6 ITY OF HEALTH CARE. THE COMMISSIONER SHALL ENCOURAGE HEALTH
7 MAINTENANCE ORGANIZATIONS TO UTILIZE A WIDE VARIETY OF
8 HEALTH-RELATED DISCIPLINES AND FACILITIES AND TO DEVELOP SERVICES
9 THAT CONTRIBUTE TO THE PREVENTION OF DISEASE AND DISABILITY AND
10 TO THE RESTORATION OF HEALTH.

11 (2) THE COMMISSIONER SHALL REGULATE THE BUSINESS AND FINAN-
12 CIAL ASPECTS OF HEALTH MAINTENANCE ORGANIZATION OPERATIONS FOR
13 THE PURPOSE OF ASSURING THAT THE ORGANIZATIONS ARE FINANCIALLY
14 SOUND AND FOLLOW ACCEPTABLE BUSINESS PRACTICES. THE COMMISSIONER
15 SHALL ASSURE THAT THE ORGANIZATIONS OPERATE IN THE INTEREST OF
16 ENROLLEES CONSISTENT WITH OVERALL HEALTH CARE COST CONTAINMENT
17 WHILE DELIVERING ACCEPTABLE QUALITY OF CARE AND SERVICES THAT ARE
18 AVAILABLE AND ACCESSIBLE TO ENROLLEES WITH APPROPRIATE ADMINIS-
19 TRATIVE COSTS AND HEALTH CARE PROVIDER INCENTIVES. A HEALTH
20 MAINTENANCE ORGANIZATION SHALL DO ALL OF THE FOLLOWING:

21 (A) PROVIDE, AS PROMPTLY AS APPROPRIATE, HEALTH MAINTENANCE
22 SERVICES IN A MANNER THAT ASSURES CONTINUITY AND IMPARTS QUALITY
23 HEALTH CARE UNDER CONDITIONS THE COMMISSIONER CONSIDERS TO BE IN
24 THE PUBLIC INTEREST.

25 (B) PROVIDE, WITHIN THE GEOGRAPHIC AREA SERVED BY THE HEALTH
26 MAINTENANCE ORGANIZATION, HEALTH MAINTENANCE SERVICES THAT ARE
27 AVAILABLE, ACCESSIBLE, AND PROVIDED AS PROMPTLY AS APPROPRIATE TO

1 EACH OF ITS ENROLLEES IN A MANNER THAT ASSURES CONTINUITY, AND
2 ARE AVAILABLE AND ACCESSIBLE TO ENROLLEES 24 HOURS A DAY AND 7
3 DAYS A WEEK FOR THE TREATMENT OF EMERGENCY EPISODES OF ILLNESS OR
4 INJURY.

5 (C) PROVIDE ADEQUATE ARRANGEMENTS FOR A CONTINUOUS EVALU-
6 ATION OF THE QUALITY OF HEALTH CARE.

7 (D) PROVIDE THAT REASONABLE PROVISIONS EXIST FOR AN ENROLLEE
8 TO OBTAIN EMERGENCY HEALTH SERVICES BOTH WITHIN AND OUTSIDE OF
9 THE GEOGRAPHIC AREA SERVED BY THE HEALTH MAINTENANCE
10 ORGANIZATION.

11 (E) PROVIDE THAT REASONABLE PROCEDURES EXIST FOR RESOLVING
12 ENROLLEE GRIEVANCES AS REQUIRED BY THIS CHAPTER OR AS OTHERWISE
13 PROVIDED BY LAW.

14 (F) BE INCORPORATED AS A DISTINCT LEGAL ENTITY UNDER THE
15 BUSINESS CORPORATION ACT, 1972 PA 284, MCL 450.1101 TO 450.2098,
16 THE NONPROFIT CORPORATION ACT, 1982 PA 162, MCL 450.2101 TO
17 450.3192, OR THE MICHIGAN LIMITED LIABILITY COMPANY ACT, 1993 PA
18 23, MCL 450.4101 TO 450.5200.

19 (G) HAVE A GOVERNING BODY THAT MEETS THE REQUIREMENTS OF
20 THIS CHAPTER.

21 SEC. 3515. (1) A HEALTH MAINTENANCE ORGANIZATION MAY PRO-
22 VIDE ADDITIONAL HEALTH MAINTENANCE SERVICES OR ANY OTHER RELATED
23 HEALTH CARE SERVICE OR TREATMENT NOT REQUIRED UNDER THIS
24 CHAPTER.

25 (2) A HEALTH MAINTENANCE ORGANIZATION MAY HAVE HEALTH MAIN-
26 TENANCE CONTRACTS WITH NOMINAL COPAYMENTS THAT ARE REQUIRED FOR
27 SPECIFIC HEALTH MAINTENANCE SERVICES. COPAYMENTS SHALL NOT

1 EXCEED 50% OF A HEALTH MAINTENANCE ORGANIZATION'S REIMBURSEMENT
2 TO AN AFFILIATED PROVIDER FOR PROVIDING THE SERVICE TO AN
3 ENROLLEE AND SHALL NOT BE BASED ON THE PROVIDER'S STANDARD CHARGE
4 FOR THE SERVICE.

5 (3) A HEALTH MAINTENANCE ORGANIZATION MAY ACCEPT FROM GOV-
6 ERNMENTAL AGENCIES AND FROM PRIVATE PERSONS PAYMENTS COVERING ANY
7 PART OF THE COST OF HEALTH MAINTENANCE CONTRACTS.

8 SEC. 3517. (1) A HEALTH MAINTENANCE CONTRACT SHALL NOT PRO-
9 VIDE FOR PAYMENT OF CASH OR OTHER MATERIAL BENEFIT TO AN ENROLL-
10 EE, EXCEPT AS STATED IN THIS CHAPTER.

11 (2) FOR AN EMERGENCY EPISODE OF ILLNESS OR INJURY THAT
12 REQUIRES IMMEDIATE TREATMENT BEFORE IT CAN BE SECURED THROUGH THE
13 HEALTH MAINTENANCE ORGANIZATION, OR FOR AN OUT-OF-AREA SERVICE
14 SPECIFICALLY AUTHORIZED BY THE HEALTH MAINTENANCE ORGANIZATION,
15 AN ENROLLEE MAY UTILIZE A PROVIDER WITHIN OR WITHOUT THIS STATE
16 NOT NORMALLY ENGAGED BY THE HEALTH MAINTENANCE ORGANIZATION TO
17 RENDER SERVICE TO ITS ENROLLEES. THE ORGANIZATION SHALL PAY REA-
18 SONABLE EXPENSES OR FEES TO THE PROVIDER OR ENROLLEE AS APPROPRI-
19 ATE IN AN INDIVIDUAL CASE. THESE TRANSACTIONS ARE NOT CONSIDERED
20 ACTS OF INSURANCE AND, EXCEPT AS PROVIDED IN THIS CHAPTER AND
21 SECTION 3406K, ARE NOT OTHERWISE SUBJECT TO THIS ACT.

22 SEC. 3519. (1) A HEALTH MAINTENANCE ORGANIZATION CONTRACT
23 AND THE CONTRACT'S RATES, INCLUDING ANY NOMINAL COPAYMENTS,
24 BETWEEN THE ORGANIZATION AND ITS SUBSCRIBERS SHALL BE FAIR,
25 SOUND, AND REASONABLE IN RELATION TO THE SERVICES PROVIDED, AND
26 THE PROCEDURES FOR OFFERING AND TERMINATING CONTRACTS SHALL NOT
27 BE UNFAIRLY DISCRIMINATORY.

1 (2) A HEALTH MAINTENANCE ORGANIZATION CONTRACT AND THE
2 CONTRACT'S RATES SHALL NOT DISCRIMINATE ON THE BASIS OF RACE,
3 COLOR, CREED, NATIONAL ORIGIN, RESIDENCE WITHIN THE APPROVED
4 SERVICE AREA OF THE HEALTH MAINTENANCE ORGANIZATION, LAWFUL OCCU-
5 PATION, SEX, HANDICAP, OR MARITAL STATUS, EXCEPT THAT MARITAL
6 STATUS MAY BE USED TO CLASSIFY INDIVIDUALS OR RISKS FOR THE PUR-
7 POSE OF INSURING FAMILY UNITS. THE COMMISSIONER MAY APPROVE A
8 RATE DIFFERENTIAL BASED ON SEX, AGE, RESIDENCE, DISABILITY, MARI-
9 TAL STATUS, OR LAWFUL OCCUPATION, IF THE DIFFERENTIAL IS SUP-
10 PORTED BY SOUND ACTUARIAL PRINCIPLES, A REASONABLE CLASSIFICATION
11 SYSTEM, AND IS RELATED TO THE ACTUAL AND CREDIBLE LOSS STATISTICS
12 OR REASONABLY ANTICIPATED EXPERIENCE FOR NEW COVERAGES.

13 (3) ALL HEALTH MAINTENANCE ORGANIZATION CONTRACTS SHALL
14 INCLUDE, AT A MINIMUM, BASIC HEALTH SERVICES.

15 SEC. 3521. (1) THE METHODOLOGY USED TO DETERMINE PREPAYMENT
16 RATES BY CATEGORY RATES CHARGED BY THE HEALTH MAINTENANCE ORGANI-
17 ZATION AND ANY CHANGES TO EITHER THE METHODOLOGY OR THE RATES
18 SHALL BE FILED WITH AND APPROVED BY THE COMMISSIONER BEFORE
19 BECOMING EFFECTIVE.

20 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL SUBMIT SUPPORT-
21 ING DATA USED IN THE DEVELOPMENT OF A PREPAYMENT RATE OR RATING
22 METHODOLOGY AND ALL OTHER DATA SUFFICIENT TO ESTABLISH THE FINAN-
23 CIAL SOUNDNESS OF THE PREPAYMENT PLAN OR RATING METHODOLOGY.

24 (3) THE COMMISSIONER MAY ANNUALLY REQUIRE A SCHEDULE OF
25 RATES FOR ALL SUBSCRIBER CONTRACTS AND RIDERS. ALL SUBMISSIONS
26 SHALL NOTE CHANGES OF RATES PREVIOUSLY FILED OR APPROVED.

1 SEC. 3523. (1) A HEALTH MAINTENANCE CONTRACT SHALL BE FILED
2 WITH AND APPROVED BY THE COMMISSIONER.

3 (2) A HEALTH MAINTENANCE CONTRACT SHALL INCLUDE ANY APPROVED
4 RIDERS, AMENDMENTS, AND THE ENROLLMENT APPLICATION.

5 (3) IN ADDITION TO THE PROVISIONS OF THIS ACT THAT APPLY TO
6 AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY OR CER-
7 TIFICATE, A HEALTH MAINTENANCE CONTRACT SHALL INCLUDE ALL OF THE
8 FOLLOWING:

9 (A) NAME AND ADDRESS OF THE ORGANIZATION.

10 (B) DEFINITIONS OF TERMS SUBJECT TO INTERPRETATION.

11 (C) THE EFFECTIVE DATE AND DURATION OF COVERAGE.

12 (D) THE CONDITIONS OF ELIGIBILITY.

13 (E) A STATEMENT OF RESPONSIBILITY FOR PAYMENTS.

14 (F) A DESCRIPTION OF SPECIFIC BENEFITS AND SERVICES AVAIL-
15 ABLE UNDER THE CONTRACT WITHIN THE SERVICE AREA, WITH RESPECTIVE
16 COPAYMENTS.

17 (G) A DESCRIPTION OF EMERGENCY AND OUT-OF-AREA SERVICES.

18 (H) A SPECIFIC DESCRIPTION OF ANY LIMITATION, EXCLUSION, AND
19 EXCEPTION, INCLUDING ANY PREEXISTING CONDITION LIMITATION,
20 GROUPED TOGETHER WITH CAPTIONS IN BOLDFACED TYPE.

21 (I) COVENANTS WHICH ADDRESS CONFIDENTIALITY, AN ENROLLEE'S
22 RIGHT TO CHOOSE OR CHANGE THE PRIMARY CARE PHYSICIAN OR OTHER
23 PROVIDERS, AVAILABILITY AND ACCESSIBILITY OF SERVICES, AND ANY
24 RIGHTS OF THE ENROLLEE TO INSPECT AND REVIEW HIS OR HER MEDICAL
25 RECORDS.

26 (J) COVENANTS OF THE SUBSCRIBER SHALL ADDRESS ALL OF THE
27 FOLLOWING SUBJECTS:

- 1 (i) TIMELY PAYMENT.
- 2 (ii) NONASSIGNMENT OF BENEFITS.
- 3 (iii) TRUTH IN APPLICATION AND STATEMENTS.
- 4 (iv) NOTIFICATION OF CHANGE IN ADDRESS.
- 5 (v) THEFT OF MEMBERSHIP IDENTIFICATION.
- 6 (K) A STATEMENT OF RESPONSIBILITIES AND RIGHTS REGARDING THE
- 7 GRIEVANCE PROCEDURE.
- 8 (L) A STATEMENT REGARDING SUBROGATION AND COORDINATION OF
- 9 BENEFITS PROVISIONS, INCLUDING ANY RESPONSIBILITY OF THE ENROLLEE
- 10 TO COOPERATE.
- 11 (M) A STATEMENT REGARDING CONVERSION RIGHTS.
- 12 (N) PROVISIONS FOR ADDING NEW FAMILY MEMBERS OR OTHER
- 13 ACQUIRED DEPENDENTS, INCLUDING CONVERSION OF INDIVIDUAL CONTRACTS
- 14 TO FAMILY CONTRACTS AND FAMILY CONTRACTS TO INDIVIDUAL CONTRACTS,
- 15 AND THE TIME CONSTRAINTS IMPOSED.
- 16 (O) PROVISIONS FOR GRACE PERIODS FOR LATE PAYMENT.
- 17 (P) A DESCRIPTION OF ANY SPECIFIC TERMS UNDER WHICH THE
- 18 HEALTH MAINTENANCE ORGANIZATION OR THE SUBSCRIBER CAN TERMINATE
- 19 THE CONTRACT.
- 20 (Q) A STATEMENT OF THE NONASSIGNABILITY OF THE CONTRACT.
- 21 SEC. 3525. (1) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION
- 22 (2), IF A HEALTH MAINTENANCE ORGANIZATION DESIRES TO CHANGE A
- 23 CONTRACT IT OFFERS TO ENROLLEES OR DESIRES TO CHANGE A RATE
- 24 CHARGED, A COPY OF THE PROPOSED REVISED CONTRACT OR RATE SHALL BE
- 25 FILED WITH THE COMMISSIONER AND SHALL NOT TAKE EFFECT UNTIL 60
- 26 DAYS AFTER THE FILING, UNLESS THE COMMISSIONER APPROVES THE
- 27 CHANGE IN WRITING BEFORE THE EXPIRATION OF 60 DAYS AFTER THE

1 FILING. IF THE COMMISSIONER CONSIDERS THAT THE PROPOSED REVISED
2 CONTRACT OR RATE IS ILLEGAL OR UNREASONABLE IN RELATION TO THE
3 SERVICES PROVIDED, THE COMMISSIONER, NOT MORE THAN 60 DAYS AFTER
4 THE PROPOSED REVISED CONTRACT OR RATE IS FILED, SHALL NOTIFY THE
5 ORGANIZATION IN WRITING, SPECIFYING THE REASONS FOR DISAPPROVAL
6 OR FOR APPROVAL WITH MODIFICATIONS. FOR AN APPROVAL WITH MODIFI-
7 CATIONS, THE NOTICE SHALL SPECIFY WHAT MODIFICATIONS IN THE
8 FILING ARE REQUIRED FOR APPROVAL, THE REASONS FOR THE MODIFICA-
9 TIONS, AND THAT THE FILING BECOMES EFFECTIVE AFTER THE MODIFICA-
10 TIONS ARE MADE AND APPROVED BY THE COMMISSIONER. THE COMMIS-
11 SIONER SHALL SCHEDULE A HEARING NOT MORE THAN 30 DAYS AFTER
12 RECEIPT OF A WRITTEN REQUEST FROM THE HEALTH MAINTENANCE ORGANI-
13 ZATION, AND THE REVISED CONTRACT OR RATE SHALL NOT TAKE EFFECT
14 UNTIL APPROVED BY THE COMMISSIONER AFTER THE HEARING. WITHIN 30
15 DAYS AFTER THE HEARING, THE COMMISSIONER SHALL NOTIFY THE ORGANI-
16 ZATION IN WRITING OF THE DISPOSITION OF THE PROPOSED REVISED CON-
17 TRACT OR RATE, TOGETHER WITH THE COMMISSIONER'S FINDINGS OF FACT
18 AND CONCLUSIONS.

19 (2) IF THE REVISED CONTRACT OR RATE IS THE RESULT OF COLLEC-
20 TIVE BARGAINING AND AFFECTS ONLY THE MEMBERS OF THE GROUPS
21 ENGAGED IN THE COLLECTIVE BARGAINING, SUBSECTION (1) DOES NOT
22 APPLY BUT THE REVISED CONTRACT OR RATE SHALL BE IMMEDIATELY FILED
23 WITH THE COMMISSIONER.

24 (3) NOT LESS THAN 30 DAYS BEFORE THE EFFECTIVE DATE OF A
25 PROPOSED CHANGE IN A HEALTH MAINTENANCE CONTRACT OR THE RATE
26 CHARGED, THE HEALTH MAINTENANCE ORGANIZATION SHALL ISSUE TO EACH
27 SUBSCRIBER OR GROUP OF SUBSCRIBERS WHO WILL BE AFFECTED BY THE

1 PROPOSED CHANGE A CLEAR WRITTEN STATEMENT STATING THE EXTENT AND
2 NATURE OF THE PROPOSED CHANGE. IF THE COMMISSIONER HAS APPROVED
3 A PROPOSED CHANGE IN A CONTRACT OR RATE IN WRITING BEFORE THE
4 EXPIRATION OF 60 DAYS AFTER THE DATE OF FILING, THE ORGANIZATION
5 IMMEDIATELY SHALL NOTIFY EACH SUBSCRIBER OR GROUP OF SUBSCRIBERS
6 WHO WILL BE AFFECTED BY THE PROPOSED CHANGE.

7 SEC. 3527. (1) UPON OBTAINING A CERTIFICATE OF AUTHORITY, A
8 HEALTH MAINTENANCE ORGANIZATION MAY ENTER INTO HEALTH MAINTENANCE
9 CONTRACTS AND ENGAGE IN OTHER ACTIVITIES CONSISTENT WITH THIS
10 CHAPTER AND OTHER APPLICABLE LAWS OF THIS STATE THAT ARE NECES-
11 SARY TO PERFORM ITS OBLIGATIONS UNDER ITS CONTRACTS.

12 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL NOT TERMINATE A
13 HEALTH MAINTENANCE CONTRACT OR DENY A RENEWAL OF A CONTRACT
14 BECAUSE OF AGE, SEX, HEALTH STATUS, NATIONAL ORIGIN, OR FREQUENCY
15 OF UTILIZATION OF MEDICALLY INDICATED SERVICES OF AN ENROLLEE OR
16 GROUP OF ENROLLEES.

17 (3) A HEALTH MAINTENANCE CONTRACT MAY BE TERMINATED FOR VIO-
18 LATION OF THE TERMS OF THE CONTRACT OR FOR NONPAYMENT OF THE
19 FIXED PREPAID SUM OR PER CAPITA PREPAYMENT SET FORTH IN THE CON-
20 TRACT IF THE FIXED PREPAID SUM OR PER CAPITA PREPAYMENT IS NOT
21 PAID WITHIN 30 DAYS AFTER THE DUE DATE.

22 SEC. 3528. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL DO
23 ALL OF THE FOLLOWING:

24 (A) ESTABLISH WRITTEN POLICIES AND PROCEDURES FOR CREDEN-
25 TIALING VERIFICATION OF ALL HEALTH PROFESSIONALS WITH WHOM THE
26 HEALTH MAINTENANCE ORGANIZATION CONTRACTS AND SHALL APPLY THESE
27 STANDARDS CONSISTENTLY.

1 (B) VERIFY THE CREDENTIALS OF A HEALTH PROFESSIONAL BEFORE
2 ENTERING INTO A CONTRACT WITH THAT HEALTH PROFESSIONAL. THE
3 HEALTH MAINTENANCE ORGANIZATION'S MEDICAL DIRECTOR OR OTHER DES-
4 IGNATED HEALTH PROFESSIONAL SHALL HAVE RESPONSIBILITY FOR, AND
5 SHALL PARTICIPATE IN, HEALTH PROFESSIONAL CREDENTIALING
6 VERIFICATION.

7 (C) ESTABLISH A CREDENTIALING VERIFICATION COMMITTEE CON-
8 SISTING OF LICENSED PHYSICIANS AND OTHER HEALTH PROFESSIONALS TO
9 REVIEW CREDENTIALING VERIFICATION INFORMATION AND SUPPORTING DOC-
10 UMENTS AND MAKE DECISIONS REGARDING CREDENTIALING VERIFICATION.

11 (D) MAKE AVAILABLE FOR REVIEW BY THE APPLYING HEALTH PROFES-
12 SIONAL UPON WRITTEN REQUEST ALL APPLICATION AND CREDENTIALING
13 VERIFICATION POLICIES AND PROCEDURES.

14 (E) RETAIN ALL RECORDS AND DOCUMENTS RELATING TO A HEALTH
15 PROFESSIONAL'S CREDENTIALING VERIFICATION PROCESS FOR AT LEAST 2
16 YEARS.

17 (F) KEEP CONFIDENTIAL ALL INFORMATION OBTAINED IN THE CRE-
18 DENTIALING VERIFICATION PROCESS, EXCEPT AS OTHERWISE PROVIDED BY
19 LAW.

20 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL OBTAIN PRIMARY
21 VERIFICATION OF AT LEAST ALL OF THE FOLLOWING INFORMATION ABOUT
22 AN APPLICANT TO BECOME AN AFFILIATED PROVIDER WITH THE HEALTH
23 MAINTENANCE ORGANIZATION:

24 (A) CURRENT LICENSE TO PRACTICE MEDICINE IN THIS STATE AND
25 HISTORY OF LICENSURE.

26 (B) CURRENT LEVEL OF PROFESSIONAL LIABILITY COVERAGE, IF
27 APPLICABLE.

- 1 (C) STATUS OF HOSPITAL PRIVILEGES, IF APPLICABLE.
- 2 (D) SPECIALTY BOARD CERTIFICATION STATUS, IF APPLICABLE.
- 3 (E) CURRENT DRUG ENFORCEMENT AGENCY (DEA) REGISTRATION CER-
- 4 TIFICATE, IF APPLICABLE.
- 5 (F) GRADUATION FROM MEDICAL SCHOOL.
- 6 (G) COMPLETION OF POSTGRADUATE TRAINING, IF APPLICABLE.
- 7 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL OBTAIN, SUBJECT
- 8 TO EITHER PRIMARY OR SECONDARY VERIFICATION AT THE HEALTH MAINTENANCE
- 9 ORGANIZATION'S DISCRETION, ALL OF THE FOLLOWING INFORMATION
- 10 ABOUT AN APPLICANT TO BECOME AN AFFILIATED PROVIDER WITH THE
- 11 HEALTH MAINTENANCE ORGANIZATION:
- 12 (A) THE HEALTH PROFESSIONAL'S LICENSE HISTORY IN THIS AND
- 13 ALL OTHER STATES.
- 14 (B) THE HEALTH PROFESSIONAL'S MALPRACTICE HISTORY.
- 15 (C) THE HEALTH PROFESSIONAL'S PRACTICE HISTORY.
- 16 (4) A HEALTH MAINTENANCE ORGANIZATION SHALL OBTAIN AT LEAST
- 17 EVERY 3 YEARS PRIMARY VERIFICATION OF ALL OF THE FOLLOWING FOR A
- 18 PARTICIPATING HEALTH PROFESSIONAL:
- 19 (A) CURRENT LICENSE TO PRACTICE MEDICINE IN THIS STATE.
- 20 (B) CURRENT LEVEL OF PROFESSIONAL LIABILITY COVERAGE, IF
- 21 APPLICABLE.
- 22 (C) STATUS OF HOSPITAL PRIVILEGES, IF APPLICABLE.
- 23 (D) CURRENT DEA REGISTRATION CERTIFICATE, IF APPLICABLE.
- 24 (E) SPECIALTY BOARD CERTIFICATION STATUS, IF APPLICABLE.
- 25 (5) A HEALTH MAINTENANCE ORGANIZATION SHALL REQUIRE ALL PAR-
- 26 TICIPATING PROVIDERS TO NOTIFY THE HEALTH MAINTENANCE
- 27 ORGANIZATION OF CHANGES IN THE STATUS OF ANY OF THE ITEMS LISTED

1 IN THIS SECTION AT ANY TIME AND IDENTIFY FOR PROVIDERS THE
2 INDIVIDUAL AT THE HEALTH MAINTENANCE ORGANIZATION TO WHOM THEY
3 SHOULD REPORT CHANGES IN THE STATUS OF AN ITEM LISTED IN THIS
4 SECTION.

5 (6) A HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE A HEALTH
6 PROFESSIONAL WITH THE OPPORTUNITY TO REVIEW AND CORRECT INFORMA-
7 TION SUBMITTED IN SUPPORT OF THAT HEALTH PROFESSIONAL'S CREDEN-
8 TIALING VERIFICATION APPLICATION AS FOLLOWS:

9 (A) EACH HEALTH PROFESSIONAL WHO IS SUBJECT TO THE CREDEN-
10 TIALING VERIFICATION PROCESS HAS THE RIGHT TO REVIEW ALL INFORMA-
11 TION, INCLUDING THE SOURCE OF THAT INFORMATION, OBTAINED BY THE
12 HEALTH MAINTENANCE ORGANIZATION TO SATISFY THE REQUIREMENTS OF
13 THIS SECTION DURING THE HEALTH MAINTENANCE ORGANIZATION'S CREDEN-
14 TIALING PROCESS.

15 (B) A HEALTH MAINTENANCE ORGANIZATION SHALL NOTIFY A HEALTH
16 PROFESSIONAL OF ANY INFORMATION OBTAINED DURING THE HEALTH MAIN-
17 TENANCE ORGANIZATION'S CREDENTIALING VERIFICATION PROCESS THAT
18 DOES NOT MEET THE HEALTH MAINTENANCE ORGANIZATION'S CREDENTIALING
19 VERIFICATION STANDARDS OR THAT VARIES SUBSTANTIALLY FROM THE
20 INFORMATION PROVIDED TO THE HEALTH MAINTENANCE ORGANIZATION BY
21 THE HEALTH PROFESSIONAL, EXCEPT THAT THE HEALTH MAINTENANCE
22 ORGANIZATION IS NOT REQUIRED TO REVEAL THE SOURCE OF INFORMATION
23 IF THE INFORMATION IS NOT OBTAINED TO MEET THE REQUIREMENTS OF
24 THIS SECTION OR IF DISCLOSURE IS PROHIBITED BY LAW.

25 (C) A HEALTH PROFESSIONAL HAS THE RIGHT TO CORRECT ANY ERRO-
26 NEOUS INFORMATION. A HEALTH MAINTENANCE ORGANIZATION SHALL HAVE
27 A FORMAL PROCESS BY WHICH A HEALTH PROFESSIONAL MAY SUBMIT

1 SUPPLEMENTAL OR CORRECTED INFORMATION TO THE HEALTH MAINTENANCE
2 ORGANIZATION'S CREDENTIALING VERIFICATION COMMITTEE AND REQUEST A
3 RECONSIDERATION OF THE HEALTH PROFESSIONAL'S CREDENTIALING VERI-
4 FICATION APPLICATION IF THE HEALTH PROFESSIONAL FEELS THAT THE
5 HEALTH CARRIER'S CREDENTIALING VERIFICATION COMMITTEE HAS
6 RECEIVED INFORMATION THAT IS INCORRECT OR MISLEADING.
7 SUPPLEMENTAL INFORMATION IS SUBJECT TO CONFIRMATION BY THE HEALTH
8 MAINTENANCE ORGANIZATION.

9 (7) IF A HEALTH MAINTENANCE ORGANIZATION CONTRACTS TO HAVE
10 ANOTHER ENTITY PERFORM THE CREDENTIALING FUNCTIONS REQUIRED BY
11 THIS SECTION, THE COMMISSIONER SHALL HOLD THE HEALTH MAINTENANCE
12 ORGANIZATION RESPONSIBLE FOR MONITORING THE ACTIVITIES OF THE
13 ENTITY WITH WHICH IT CONTRACTS AND FOR ENSURING THAT THE REQUIRE-
14 MENTS OF THIS SECTION ARE MET.

15 (8) NOTHING IN THIS ACT SHALL BE CONSTRUED TO REQUIRE A
16 HEALTH MAINTENANCE ORGANIZATION TO SELECT A PROVIDER AS A PARTIC-
17 IPATING PROVIDER SOLELY BECAUSE THE PROVIDER MEETS THE HEALTH
18 MAINTENANCE ORGANIZATION'S CREDENTIALING VERIFICATION STANDARDS,
19 OR TO PREVENT A HEALTH MAINTENANCE ORGANIZATION FROM UTILIZING
20 SEPARATE OR ADDITIONAL CRITERIA IN SELECTING THE HEALTH PROFES-
21 SIONALS WITH WHOM IT CONTRACTS.

22 SEC. 3529. (1) A HEALTH MAINTENANCE ORGANIZATION MAY CON-
23 TRACT WITH OR EMPLOY HEALTH PROFESSIONALS ON THE BASIS OF COST,
24 QUALITY, AVAILABILITY OF SERVICES TO THE MEMBERSHIP, CONFORMITY
25 TO THE ADMINISTRATIVE PROCEDURES OF THE HEALTH MAINTENANCE ORGAN-
26 IZATION, AND OTHER FACTORS RELEVANT TO DELIVERY OF ECONOMICAL,
27 QUALITY CARE, BUT SHALL NOT DISCRIMINATE SOLELY ON THE BASIS OF

1 THE CLASS OF HEALTH PROFESSIONALS TO WHICH THE HEALTH
2 PROFESSIONAL BELONGS.

3 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL ENTER INTO CON-
4 TRACTS WITH PROVIDERS THROUGH WHICH HEALTH CARE SERVICES ARE USU-
5 ALLY PROVIDED TO ENROLLEES UNDER THE HEALTH MAINTENANCE ORGANIZA-
6 TION PLAN.

7 (3) AN AFFILIATED PROVIDER CONTRACT SHALL PROHIBIT THE PRO-
8 VIDER FROM SEEKING PAYMENT FROM THE ENROLLEE FOR SERVICES PRO-
9 VIDED PURSUANT TO THE PROVIDER CONTRACT, EXCEPT THAT THE CONTRACT
10 MAY ALLOW AFFILIATED PROVIDERS TO COLLECT COPAYMENTS DIRECTLY
11 FROM ENROLLEES.

12 (4) AN AFFILIATED PROVIDER CONTRACT SHALL CONTAIN PROVISIONS
13 ASSURING ALL OF THE FOLLOWING:

14 (A) THE PROVIDER MEETS APPLICABLE LICENSURE OR CERTIFICATION
15 REQUIREMENTS.

16 (B) APPROPRIATE ACCESS BY THE HEALTH MAINTENANCE ORGANIZA-
17 TION TO RECORDS OR REPORTS CONCERNING SERVICES TO ITS ENROLLEES.

18 (C) THE PROVIDER COOPERATES WITH THE HEALTH MAINTENANCE
19 ORGANIZATION'S QUALITY ASSURANCE ACTIVITIES.

20 (5) THE COMMISSIONER MAY WAIVE THE CONTRACT REQUIREMENT
21 UNDER SUBSECTION (2) IF A HEALTH MAINTENANCE ORGANIZATION HAS
22 DEMONSTRATED THAT IT IS UNABLE TO OBTAIN A CONTRACT AND ACCESSI-
23 BILITY TO PATIENT CARE WOULD NOT BE COMPROMISED. WHEN 10% OR
24 MORE OF A HEALTH MAINTENANCE ORGANIZATION'S ELECTIVE INPATIENT
25 ADMISSIONS, OR PROJECTED ADMISSIONS FOR A NEW HEALTH MAINTENANCE
26 ORGANIZATION, OCCUR IN HOSPITALS WITH WHICH THE HEALTH
27 MAINTENANCE ORGANIZATION DOES NOT HAVE CONTRACTS OR AGREEMENTS

1 THAT PROTECT ENROLLEES FROM LIABILITY FOR AUTHORIZED ADMISSIONS
2 AND SERVICES, THE HEALTH MAINTENANCE ORGANIZATION MAY BE REQUIRED
3 TO MAINTAIN A HOSPITAL RESERVE FUND EQUAL TO 3 MONTHS' PROJECTED
4 CLAIMS FROM SUCH HOSPITALS.

5 (6) A HEALTH MAINTENANCE ORGANIZATION SHALL SUBMIT TO THE
6 COMMISSIONER FOR APPROVAL STANDARD CONTRACT FORMATS PROPOSED FOR
7 USE WITH ITS AFFILIATED PROVIDERS AND ANY SUBSTANTIVE CHANGES TO
8 THOSE CONTRACTS. THE CONTRACT FORMAT OR CHANGE IS CONSIDERED
9 APPROVED 30 DAYS AFTER FILING UNLESS APPROVED OR DISAPPROVED
10 WITHIN THE 30 DAYS. AS USED IN THIS SUBSECTION, "SUBSTANTIVE
11 CHANGES TO CONTRACT FORMATS" MEANS A CHANGE TO A PROVIDER CON-
12 TRACT THAT ALTERS THE METHOD OF PAYMENT TO A PROVIDER, ALTERS THE
13 RISK ASSUMED BY EACH PARTY TO THE CONTRACT, OR AFFECTS A PROVI-
14 SION REQUIRED BY LAW.

15 (7) A HEALTH MAINTENANCE ORGANIZATION OR APPLICANT SHALL
16 PROVIDE EVIDENCE THAT IT HAS EMPLOYED, OR HAS EXECUTED AFFILIA-
17 TION CONTRACTS WITH, A SUFFICIENT NUMBER OF PROVIDERS TO ENABLE
18 IT TO DELIVER THE HEALTH MAINTENANCE SERVICES IT PROPOSES TO
19 OFFER.

20 SEC. 3530. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL
21 MAINTAIN CONTRACTS WITH THOSE NUMBERS AND THOSE TYPES OF AFFILI-
22 ATED PROVIDERS THAT ARE SUFFICIENT TO ASSURE THAT COVERED SERV-
23 ICES ARE AVAILABLE TO ITS ENROLLEES WITHOUT UNREASONABLE DELAY.
24 THE COMMISSIONER SHALL DETERMINE WHAT IS SUFFICIENT AS PROVIDED
25 IN THIS SECTION AND AS MAY BE ESTABLISHED BY REFERENCE TO REASON-
26 ABLE CRITERIA USED BY THE HEALTH MAINTENANCE ORGANIZATION,
27 INCLUDING, BUT NOT LIMITED TO, PROVIDER-COVERED PERSON RATIOS BY

1 SPECIALTY, PRIMARY CARE PROVIDER-COVERED PERSON RATIOS,
2 GEOGRAPHIC ACCESSIBILITY, WAITING TIMES FOR APPOINTMENTS WITH
3 PARTICIPATING PROVIDERS, HOURS OF OPERATION, AND THE VOLUME OF
4 TECHNOLOGICAL AND SPECIALTY SERVICES AVAILABLE TO SERVE THE NEEDS
5 OF ENROLLEES REQUIRING TECHNOLOGICALLY ADVANCED OR SPECIALTY
6 CARE.

7 (2) IF A HEALTH MAINTENANCE ORGANIZATION HAS AN INSUFFICIENT
8 NUMBER OR TYPE OF PARTICIPATING PROVIDERS TO PROVIDE A COVERED
9 BENEFIT, THE HEALTH MAINTENANCE ORGANIZATION SHALL ENSURE THAT
10 THE ENROLLEE OBTAINS THE COVERED BENEFIT AT NO GREATER COST TO
11 THE ENROLLEE THAN IF THE BENEFIT WERE OBTAINED FROM PARTICIPATING
12 PROVIDERS, OR SHALL MAKE OTHER ARRANGEMENTS ACCEPTABLE TO THE
13 COMMISSIONER.

14 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL ESTABLISH AND
15 MAINTAIN ADEQUATE ARRANGEMENTS TO ENSURE REASONABLE PROXIMITY OF
16 PARTICIPATING PROVIDERS TO THE BUSINESS OR PERSONAL RESIDENCE OF
17 ENROLLEES. IN DETERMINING WHETHER A HEALTH MAINTENANCE ORGANIZA-
18 TION HAS COMPLIED WITH THIS PROVISION, THE COMMISSIONER SHALL
19 GIVE DUE CONSIDERATION TO THE RELATIVE AVAILABILITY OF HEALTH
20 CARE PROVIDERS IN THE SERVICE AREA.

21 SEC. 3531. (1) THIS SECTION APPLIES IF A HEALTH MAINTENANCE
22 ORGANIZATION CONTRACTS WITH HEALTH CARE PROVIDERS TO BECOME
23 AFFILIATED PROVIDERS OR OFFERS A PRUDENT PURCHASER CONTRACT.

24 (2) A HEALTH MAINTENANCE ORGANIZATION MAY ENTER INTO A CON-
25 TRACT WITH 1 OR MORE HEALTH CARE PROVIDERS TO CONTROL HEALTH CARE
26 COSTS, ASSURE APPROPRIATE UTILIZATION OF HEALTH MAINTENANCE
27 SERVICES, AND MAINTAIN QUALITY OF HEALTH CARE. THE HEALTH

1 MAINTENANCE ORGANIZATION MAY LIMIT THE NUMBER OF CONTRACTS
2 ENTERED INTO UNDER THIS SECTION IF THE NUMBER OF CONTRACTS IS
3 SUFFICIENT TO ASSURE REASONABLE LEVELS OF ACCESS TO HEALTH MAIN-
4 TENANCE SERVICES FOR RECIPIENTS OF THOSE SERVICES. THE NUMBER OF
5 CONTRACTS AUTHORIZED BY THIS SECTION THAT ARE NECESSARY TO ASSURE
6 REASONABLE LEVELS OF ACCESS TO HEALTH MAINTENANCE SERVICES FOR
7 RECIPIENTS SHALL BE DETERMINED BY THE HEALTH MAINTENANCE ORGANI-
8 ZATION AS APPROVED BY THE COMMISSIONER UNDER THIS CHAPTER.
9 HOWEVER, THE HEALTH MAINTENANCE ORGANIZATION SHALL OFFER A CON-
10 TRACT, COMPARABLE TO THOSE CONTRACTS ENTERED INTO WITH OTHER
11 AFFILIATED PROVIDERS, TO AT LEAST 1 HEALTH CARE PROVIDER THAT
12 PROVIDES THE APPLICABLE HEALTH MAINTENANCE SERVICES AND IS
13 LOCATED WITHIN A REASONABLE DISTANCE FROM THE RECIPIENTS OF THOSE
14 HEALTH MAINTENANCE SERVICES, IF A HEALTH CARE PROVIDER THAT PRO-
15 VIDES THE APPLICABLE HEALTH MAINTENANCE SERVICES IS LOCATED
16 WITHIN THAT REASONABLE DISTANCE.

17 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL GIVE ALL HEALTH
18 CARE PROVIDERS THAT PROVIDE THE APPLICABLE HEALTH MAINTENANCE
19 SERVICES AND ARE LOCATED IN THE GEOGRAPHIC AREA SERVED BY THE
20 HEALTH MAINTENANCE ORGANIZATION AN OPPORTUNITY TO APPLY TO THE
21 HEALTH MAINTENANCE ORGANIZATION TO BECOME AN AFFILIATED
22 PROVIDER.

23 (4) A CONTRACT SHALL BE BASED UPON THE FOLLOWING WRITTEN
24 STANDARDS WHICH SHALL BE FILED BY THE HEALTH MAINTENANCE ORGANI-
25 ZATION WITH THE COMMISSIONER ON A FORM AND IN A MANNER THAT IS
26 UNIFORMLY DEVELOPED AND APPLIED BY THE COMMISSIONER:

1 (A) STANDARDS FOR MAINTAINING QUALITY HEALTH CARE.

2 (B) STANDARDS FOR CONTROLLING HEALTH CARE COSTS.

3 (C) STANDARDS FOR ASSURING APPROPRIATE UTILIZATION OF HEALTH
4 CARE SERVICES.

5 (D) STANDARDS FOR ASSURING REASONABLE LEVELS OF ACCESS TO
6 HEALTH CARE SERVICES.

7 (E) OTHER STANDARDS CONSIDERED APPROPRIATE BY THE HEALTH
8 MAINTENANCE ORGANIZATION.

9 (5) IF THE COMMISSIONER DETERMINES THAT STANDARDS UNDER
10 SUBSECTION (4) ARE DUPLICATIVE OF STANDARDS ALREADY FILED BY THE
11 HEALTH MAINTENANCE ORGANIZATION, THOSE DUPLICATIVE STANDARDS NEED
12 NOT BE FILED UNDER SUBSECTION (4).

13 (6) A HEALTH MAINTENANCE ORGANIZATION SHALL DEVELOP AND
14 INSTITUTE PROCEDURES THAT ARE DESIGNED TO NOTIFY HEALTH CARE PRO-
15 VIDERS THAT PROVIDE THE APPLICABLE HEALTH MAINTENANCE SERVICES
16 AND ARE LOCATED IN THE GEOGRAPHIC AREA SERVED BY THE ORGANIZATION
17 OF THE ACCEPTANCE OF APPLICATIONS FOR A PROVIDER PANEL. THE PRO-
18 CEDURES SHALL INCLUDE THE GIVING OF NOTICE TO THOSE PROVIDERS
19 UPON REQUEST AND SHALL INCLUDE PUBLICATION IN A NEWSPAPER WITH
20 GENERAL CIRCULATION IN THE GEOGRAPHIC AREA SERVED BY THE ORGANI-
21 ZATION AT LEAST 30 DAYS BEFORE THE INITIAL PROVIDER APPLICATION
22 PERIOD.

23 (7) A HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE FOR AN
24 INITIAL 60-DAY PROVIDER APPLICATION PERIOD DURING WHICH PROVIDERS
25 MAY APPLY TO THE HEALTH MAINTENANCE ORGANIZATION TO BECOME AFFIL-
26 IATED PROVIDERS. A HEALTH MAINTENANCE ORGANIZATION THAT HAS
27 ENTERED INTO A CONTRACT WITH AN AFFILIATED PROVIDER SHALL

1 PROVIDE, AT LEAST ONCE EVERY 4 YEARS, FOR A 60-DAY PROVIDER
2 APPLICATION PERIOD DURING WHICH A PROVIDER MAY APPLY TO THE
3 ORGANIZATION TO BECOME AN AFFILIATED PROVIDER. NOTICE OF THIS
4 PROVIDER APPLICATION PERIOD SHALL BE GIVEN TO PROVIDERS UPON
5 REQUEST AND SHALL BE PUBLISHED IN A NEWSPAPER WITH GENERAL CIRCU-
6 LATION IN THE GEOGRAPHIC AREA SERVED BY THE ORGANIZATION AT LEAST
7 30 DAYS BEFORE THE COMMENCEMENT OF THE PROVIDER APPLICATION
8 PERIOD. UPON RECEIPT OF A REQUEST BY A HEALTH CARE PROVIDER, THE
9 ORGANIZATION SHALL PROVIDE THE WRITTEN STANDARDS REQUIRED UNDER
10 THIS CHAPTER TO THE HEALTH CARE PROVIDER. WITHIN 90 DAYS AFTER
11 THE CLOSE OF A PROVIDER APPLICATION PERIOD, OR WITHIN 30 DAYS
12 FOLLOWING THE COMPLETION OF THE APPLICABLE PHYSICIAN CREDENTIAL-
13 ING PROCESS, WHICHEVER IS LATER, A HEALTH MAINTENANCE ORGANIZA-
14 TION SHALL NOTIFY AN APPLICANT IN WRITING AS TO WHETHER THE
15 APPLICATION TO BECOME AN AFFILIATED PROVIDER HAS BEEN ACCEPTED OR
16 REJECTED. IF AN APPLICANT HAS BEEN REJECTED, THE HEALTH MAINTE-
17 NANCE ORGANIZATION SHALL STATE IN WRITING THE REASONS FOR REJEC-
18 TION, CITING 1 OR MORE OF THE STANDARDS.

19 (8) A HEALTH CARE PROVIDER WHOSE CONTRACT AS AN AFFILIATED
20 PROVIDER IS TERMINATED SHALL BE PROVIDED UPON REQUEST WITH A
21 WRITTEN EXPLANATION BY THE ORGANIZATION OF THE REASONS FOR THE
22 TERMINATION.

23 (9) A HEALTH MAINTENANCE ORGANIZATION THAT IS PROVIDING PRU-
24 DENT PURCHASER AGREEMENT SERVICES TO AN INSURER SHALL PROVIDE THE
25 INSURER ON A TIMELY BASIS WITH INFORMATION REQUESTED BY THE
26 INSURER THAT THE ORGANIZATION HAS AND THAT THE INSURER NEEDS TO
27 COMPLY WITH SECTION 2212.

1 SEC. 3533. (1) A HEALTH MAINTENANCE ORGANIZATION MAY OFFER
2 PRUDENT PURCHASER CONTRACTS TO GROUPS OR INDIVIDUALS AND IN CON-
3 JUNCTION WITH THOSE CONTRACTS A HEALTH MAINTENANCE ORGANIZATION
4 MAY PAY OR MAY REIMBURSE ENROLLEES, OR MAY CONTRACT WITH ANOTHER
5 ENTITY TO PAY OR REIMBURSE ENROLLEES, FOR UNAUTHORIZED SERVICES
6 OR FOR SERVICES BY NONAFFILIATED PROVIDERS IN ACCORDANCE WITH THE
7 TERMS OF THE CONTRACT AND SUBJECT TO COPAYMENTS, DEDUCTIBLES, OR
8 OTHER FINANCIAL PENALTIES DESIGNED TO ENCOURAGE ENROLLEES TO
9 OBTAIN SERVICES FROM THE ORGANIZATION'S PROVIDERS.

10 (2) PRUDENT PURCHASER CONTRACTS AND THE RATES CHARGED FOR
11 THEM ARE SUBJECT TO THE SAME REGULATORY REQUIREMENTS AS HEALTH
12 MAINTENANCE CONTRACTS. THE RATES CHARGED BY AN ORGANIZATION FOR
13 COVERAGE UNDER CONTRACTS ISSUED UNDER THIS SECTION SHALL NOT BE
14 UNREASONABLY LOWER THAN WHAT IS NECESSARY TO MEET THE EXPENSES OF
15 THE ORGANIZATION FOR PROVIDING THIS COVERAGE AND SHALL NOT HAVE
16 AN ANTICOMPETITIVE EFFECT OR RESULT IN PREDATORY PRICING IN RELA-
17 TION TO PRUDENT PURCHASER AGREEMENT COVERAGES OFFERED BY OTHER
18 ORGANIZATIONS.

19 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL NOT ISSUE PRU-
20 DENT PURCHASER CONTRACTS UNLESS IT IS IN FULL COMPLIANCE WITH THE
21 REQUIREMENTS FOR ADEQUATE WORKING CAPITAL, STATUTORY DEPOSITS,
22 AND RESERVES AS PROVIDED IN THIS CHAPTER AND IT IS NOT OPERATING
23 UNDER ANY LIMITATION TO ITS AUTHORIZATION TO DO BUSINESS IN THIS
24 STATE.

25 (4) A HEALTH MAINTENANCE ORGANIZATION SHALL MAINTAIN FINAN-
26 CIAL RECORDS FOR ITS PRUDENT PURCHASER CONTRACTS AND ACTIVITIES

1 IN A FORM SEPARATE OR SEPARABLE FROM THE FINANCIAL RECORDS OF
2 OTHER OPERATIONS AND ACTIVITIES CARRIED ON BY THE ORGANIZATION.

3 SEC. 3535. SOLICITATION OF ENROLLEES OR ADVERTISING OF THE
4 SERVICES, CHARGES, OR OTHER NONPROFESSIONAL ASPECTS OF THE HEALTH
5 MAINTENANCE ORGANIZATION'S OPERATION UNDER THIS SECTION SHALL NOT
6 BE CONSTRUED TO BE IN VIOLATION OF LAWS RELATING TO SOLICITATION
7 OR ADVERTISING BY HEALTH PROFESSIONALS, BUT SHALL NOT INCLUDE
8 ADVERTISING THAT MAKES ANY QUALITATIVE JUDGMENT AS TO A HEALTH
9 PROFESSIONAL WHO PROVIDES SERVICES FOR A HEALTH MAINTENANCE
10 ORGANIZATION. A SOLICITATION OR ADVERTISING SHALL NOT OFFER A
11 MATERIAL BENEFIT OR OTHER THING OF VALUE AS AN INDUCEMENT TO PRO-
12 SPECTIVE SUBSCRIBERS OTHER THAN THE SERVICES OF THE
13 ORGANIZATION.

14 SEC. 3537. (1) AFTER THE INITIAL 24 MONTHS OF OPERATION, A
15 HEALTH MAINTENANCE ORGANIZATION SHALL HAVE AN OPEN ENROLLMENT
16 PERIOD OF NOT LESS THAN 30 DAYS AT LEAST ONCE DURING EACH CONSEC-
17 UTIVE 12-MONTH PERIOD. DURING EACH ENROLLMENT PERIOD, THE HEALTH
18 MAINTENANCE ORGANIZATION SHALL ACCEPT UP TO ITS CAPACITY AS
19 DETERMINED BY THE ORGANIZATION AND SUBMITTED TO THE COMMISSIONER
20 NOT LESS THAN 60 DAYS BEFORE THE COMMENCEMENT OF THE ENROLLMENT
21 PERIOD, INDIVIDUALS IN THE ORDER IN WHICH THEY APPLY FOR ENROLL-
22 MENT IN A MANNER THAT DOES NOT UNFAIRLY DISCRIMINATE ON THE BASIS
23 OF AGE, SEX, RACE, HEALTH, OR ECONOMIC STATUS. THE COMMISSIONER
24 MAY WAIVE COMPLIANCE BY THE ORGANIZATION WITH THIS OPEN ENROLL-
25 MENT REQUIREMENT FOR ANY 12-MONTH PERIOD FOR WHICH THE ORGANIZA-
26 TION DEMONSTRATES TO THE COMMISSIONER'S SATISFACTION THAT EITHER
27 OF THE FOLLOWING WILL OCCUR:

1 (A) IT HAS ENROLLED, OR WILL BE COMPELLED TO ENROLL, A
2 DISPROPORTIONATE NUMBER OF INDIVIDUALS WHO ARE LIKELY TO UTILIZE
3 ITS SERVICES MORE OFTEN THAN AN ACTUARIALLY DETERMINED AVERAGE AS
4 DETERMINED UNDER RULES PROMULGATED BY THE COMMISSIONER, AND
5 ENROLLMENT DURING AN OPEN ENROLLMENT PERIOD OF AN ADDITIONAL
6 NUMBER OF THOSE INDIVIDUALS WILL JEOPARDIZE ITS ECONOMIC
7 VIABILITY.

8 (B) IF IT MAINTAINED AN OPEN ENROLLMENT PERIOD, IT WOULD NOT
9 BE ABLE TO COMPLY WITH THE RULES PROMULGATED UNDER THIS CHAPTER.

10 (2) A HEALTH MAINTENANCE ORGANIZATION PROVIDING HEALTH MAIN-
11 TENANCE SERVICES TO SPECIFIED GROUPS OF INDIVIDUALS MAY ACCEPT
12 MEMBERS OF THE GROUPS BEFORE ACCEPTING OTHER INDIVIDUALS IN THE
13 ORDER IN WHICH THEY APPLY.

14 (3) A HEALTH MAINTENANCE ORGANIZATION WHICH, UNDER THIS SEC-
15 TION, ENROLLS INDIVIDUALS WHO ARE NOT MEMBERS OF A GROUP MAY RATE
16 THIS NONGROUP MEMBERSHIP ON THE BASIS OF ACTUAL AND CREDIBLE LOSS
17 EXPERIENCE.

18 SEC. 3539. (1) FOR AN INDIVIDUAL COVERED UNDER A NONGROUP
19 CONTRACT OR UNDER A CONTRACT NOT COVERED UNDER SUBSECTION (2), A
20 HEALTH MAINTENANCE ORGANIZATION MAY EXCLUDE OR LIMIT COVERAGE FOR
21 A CONDITION ONLY IF THE EXCLUSION OR LIMITATION RELATES TO A CON-
22 DITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT
23 WAS RECOMMENDED OR RECEIVED WITHIN 6 MONTHS BEFORE ENROLLMENT AND
24 THE EXCLUSION OR LIMITATION DOES NOT EXTEND FOR MORE THAN 6
25 MONTHS AFTER THE EFFECTIVE DATE OF THE HEALTH MAINTENANCE
26 CONTRACT.

1 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL NOT EXCLUDE OR
2 LIMIT COVERAGE FOR A PREEXISTING CONDITION FOR AN INDIVIDUAL
3 COVERED UNDER A GROUP CONTRACT.

4 (3) EXCEPT AS PROVIDED IN SUBSECTION (5), A HEALTH MAINTENANCE ORGANIZATION THAT HAS ISSUED A NONGROUP CONTRACT SHALL
5 RENEW OR CONTINUE IN FORCE THE CONTRACT AT THE OPTION OF THE
6 INDIVIDUAL.

8 (4) EXCEPT AS PROVIDED IN SUBSECTION (5), A HEALTH MAINTENANCE ORGANIZATION THAT HAS ISSUED A GROUP CONTRACT SHALL RENEW
9 OR CONTINUE IN FORCE THE CONTRACT AT THE OPTION OF THE SPONSOR OF
10 THE PLAN.

12 (5) GUARANTEED RENEWAL IS NOT REQUIRED IN CASES OF FRAUD,
13 INTENTIONAL MISREPRESENTATION OF MATERIAL FACT, LACK OF PAYMENT,
14 IF THE HEALTH MAINTENANCE ORGANIZATION NO LONGER OFFERS THAT PARTICULAR TYPE OF COVERAGE IN THE MARKET, OR IF THE INDIVIDUAL OR
15 GROUP MOVES OUTSIDE THE SERVICE AREA.

17 (6) AS USED IN THIS SECTION, "GROUP" MEANS A GROUP OF 2 OR
18 MORE SUBSCRIBERS.

19 SEC. 3541. A HEALTH MAINTENANCE ORGANIZATION SHALL NOT PROHIBIT OR DISCOURAGE A HEALTH PROFESSIONAL FROM ADVOCATING ON
20 BEHALF OF AN ENROLLEE FOR APPROPRIATE MEDICAL TREATMENT OPTIONS
21 PURSUANT TO THE GRIEVANCE PROCEDURE IN SECTION 2213 OR THE
22 PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT OR FROM DISCUSSING WITH
23 AN ENROLLEE OR PROVIDER ANY OF THE FOLLOWING:

25 (A) HEALTH CARE TREATMENTS AND SERVICES.

26 (B) QUALITY ASSURANCE PLANS REQUIRED BY LAW, IF APPLICABLE.

1 (C) THE FINANCIAL RELATIONSHIPS BETWEEN THE HEALTH
2 MAINTENANCE ORGANIZATION AND THE HEALTH PROFESSIONAL INCLUDING
3 ALL OF THE FOLLOWING AS APPLICABLE:

4 (i) WHETHER A FEE-FOR-SERVICE ARRANGEMENT EXISTS, UNDER
5 WHICH THE PROVIDER IS PAID A SPECIFIED AMOUNT FOR EACH COVERED
6 SERVICE RENDERED TO THE PARTICIPANT.

7 (ii) WHETHER A CAPITATION ARRANGEMENT EXISTS, UNDER WHICH A
8 FIXED AMOUNT IS PAID TO THE PROVIDER FOR ALL COVERED SERVICES
9 THAT ARE OR MAY BE RENDERED TO EACH COVERED INDIVIDUAL OR
10 FAMILY.

11 (iii) WHETHER PAYMENTS TO PROVIDERS ARE MADE BASED ON STAN-
12 DARDS RELATING TO COST, QUALITY, OR PATIENT SATISFACTION.

[SEC. 3542. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL NOT USE
ANY FINANCIAL INCENTIVE OR MAKE ANY PAYMENT TO A HEALTH PROFESSIONAL
THAT ACTS DIRECTLY OR INDIRECTLY AS AN INDUCEMENT TO DENY, REDUCE,
LIMIT, OR DELAY SPECIFIC MEDICALLY NECESSARY AND APPROPRIATE
SERVICES.

(2) SUBSECTION (1) DOES NOT PROHIBIT PAYMENT ARRANGEMENTS THAT
ARE NOT TIED TO SPECIFIC MEDICAL DECISIONS OR PROHIBIT THE USE OF
RISK SHARING AS OTHERWISE AUTHORIZED IN THIS CHAPTER.]

13 SEC. 3543. (1) WITH THE COMMISSIONER'S APPROVAL, A HEALTH
14 MAINTENANCE ORGANIZATION MAY OWN OR INVEST IN A THIRD PARTY
15 ADMINISTRATOR. THE COMMISSIONER SHALL GRANT APPROVAL UPON BEING
16 SATISFIED THAT ALL OF THE FOLLOWING CONDITIONS ARE MET:

17 (A) THE THIRD PARTY ADMINISTRATOR IS INCORPORATED AS A DIS-
18 TINCT LEGAL ENTITY UNDER THE BUSINESS CORPORATION ACT, 1972 PA
19 284, MCL 450.1101 TO 450.2098, THE NONPROFIT CORPORATION ACT,
20 1982 PA 162, MCL 450.2101 TO 450.3192, OR THE MICHIGAN LIMITED
21 LIABILITY COMPANY ACT, 1993 PA 23, MCL 450.4101 TO 450.5200.

22 (B) THE THIRD PARTY ADMINISTRATOR HAS A CERTIFICATE OF
23 AUTHORITY ISSUED PURSUANT TO THE THIRD PARTY ADMINISTRATOR ACT,
24 1984 PA 218, MCL 550.901 TO 550.962.

25 (C) BASED ON GENERALLY ACCEPTED ACCOUNTING PRINCIPLES, THE
26 PROPOSED OR OPERATING THIRD PARTY ADMINISTRATOR IS FINANCIALLY
27 SOUND AND MAINTAINS ADEQUATE WORKING CAPITAL.

1 (D) THE INVESTMENT IN THE THIRD PARTY ADMINISTRATOR BY THE
2 HEALTH MAINTENANCE ORGANIZATION DOES NOT ENDANGER THE CONTINUED
3 OPERATION OF THE HEALTH MAINTENANCE ORGANIZATION.

4 (E) THE THIRD PARTY ADMINISTRATOR MAINTAINS FINANCIAL
5 RECORDS FOR ITS ACTIVITIES SEPARATE OR SEPARABLE FROM THE FINAN-
6 CIAL RECORDS OF THE HEALTH MAINTENANCE ORGANIZATION.

7 (2) EXCEPT AS OTHERWISE PROVIDED IN THIS CHAPTER, A THIRD
8 PARTY ADMINISTRATOR OPERATING UNDER THIS SECTION IS FULLY SUBJECT
9 TO THE THIRD PARTY ADMINISTRATOR ACT, 1984 PA 218, MCL 550.901 TO
10 550.962. NEITHER THIS SECTION NOR THE OPERATION OF THE THIRD
11 PARTY ADMINISTRATOR AS A SEPARATE LEGAL ENTITY DIMINISHES THE
12 COMMISSIONER'S AUTHORITY UNDER THIS ACT OR OTHER LAWS REGULATING
13 THE HEALTH MAINTENANCE ORGANIZATION OR THEIR PARENT COMPANIES.

14 (3) AN INDIVIDUAL COVERED UNDER A PLAN ADMINISTERED BY A
15 THIRD PARTY ADMINISTRATOR OPERATING UNDER THIS SECTION IS NOT
16 LIABLE FOR INCURRED MEDICAL EXPENSES FOR COVERED SERVICES IF THE
17 PLAN SPONSOR CONTINUES TO PAY THE MEDICAL EXPENSES THAT ARE ELI-
18 GIBLE FOR PAYMENT.

19 SEC. 3545. WITH THE COMMISSIONER'S PRIOR APPROVAL, A HEALTH
20 MAINTENANCE ORGANIZATION MAY ACQUIRE OBLIGATIONS FROM ANOTHER
21 MANAGED CARE ENTITY. THE COMMISSIONER SHALL NOT GRANT PRIOR
22 APPROVAL UNLESS THE COMMISSIONER DETERMINES THAT THE TRANSACTION
23 WILL NOT JEOPARDIZE THE HEALTH MAINTENANCE ORGANIZATION'S FINAN-
24 CIAL SECURITY.

25 SEC. 3547. (1) THE COMMISSIONER AT ANY TIME MAY VISIT OR
26 EXAMINE THE HEALTH CARE SERVICE OPERATIONS OF A HEALTH

1 MAINTENANCE ORGANIZATION AND CONSULT WITH ENROLLEES TO THE EXTENT
2 NECESSARY TO CARRY OUT THE INTENT OF THIS CHAPTER.

3 (2) IN ADDITION TO THE AUTHORITY GRANTED UNDER CHAPTER 2,
4 THE COMMISSIONER:

5 (A) SHALL HAVE ACCESS TO ALL INFORMATION OF THE HEALTH MAIN-
6 TENANCE ORGANIZATION RELATING TO THE DELIVERY OF HEALTH SERVICES,
7 INCLUDING, BUT NOT LIMITED TO BOOKS, PAPERS, COMPUTER DATABASES,
8 AND DOCUMENTS, IN A MANNER THAT PRESERVES THE CONFIDENTIALITY OF
9 THE HEALTH RECORDS OF INDIVIDUAL ENROLLEES.

10 (B) MAY REQUIRE THE SUBMISSION OF INFORMATION REGARDING A
11 PROPOSED CONTRACT BETWEEN A HEALTH MAINTENANCE ORGANIZATION AND
12 AN AFFILIATED PROVIDER AS THE COMMISSIONER CONSIDERS NECESSARY TO
13 ASSURE THAT THE CONTRACT IS IN COMPLIANCE WITH THIS CHAPTER.

14 SEC. 3548. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL KEEP
15 ALL OF ITS BOOKS, RECORDS, AND FILES AT OR UNDER THE CONTROL OF
16 ITS PRINCIPAL PLACE OF DOING BUSINESS IN THIS STATE, AND SHALL
17 KEEP A RECORD OF ALL OF ITS SECURITIES, NOTES, MORTGAGES, OR
18 OTHER EVIDENCES OF INDEBTEDNESS, REPRESENTING INVESTMENT OF FUNDS
19 AT ITS PRINCIPAL PLACE OF DOING BUSINESS IN THIS STATE IN THE
20 SAME MANNER AS PROVIDED FOR IN SECTION 5256.

21 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL MAINTAIN FINAN-
22 CIAL RECORDS FOR ITS HEALTH MAINTENANCE ACTIVITIES SEPARATE FROM
23 THE FINANCIAL RECORDS OF ANY OTHER OPERATION OR ACTIVITY CARRIED
24 ON BY THE PERSON LICENSED UNDER THIS CHAPTER TO OPERATE THE
25 HEALTH MAINTENANCE ORGANIZATION.

26 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL HOLD AND
27 MAINTAIN LEGAL TITLE TO ALL ASSETS, INCLUDING CASH AND

1 INVESTMENTS. HEALTH MAINTENANCE ORGANIZATION FUNDS AND ASSETS
2 SHALL NOT BE COMMINGLED WITH AFFILIATES OR OTHER ENTITIES IN
3 POOLING OR CASH MANAGEMENT TYPE ARRANGEMENTS. ALL HEALTH MAINTENANCE
4 ORGANIZATION ASSETS SHALL BE HELD SEPARATE FROM ALL OTHER
5 ACTIVITIES OF OTHER MEMBERS IN A HOLDING COMPANY SYSTEM.

6 SEC. 3549. A HEALTH MAINTENANCE ORGANIZATION SHALL NOTIFY
7 THE APPROPRIATE BOARD AS TO ANY DISCIPLINARY ACTION TAKEN BY THE
8 HEALTH MAINTENANCE ORGANIZATION FOR ANY OF THE GROUNDS UNDER
9 SECTION 16221 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL
10 333.16221, THAT RESULTS IN A CHANGE OF EMPLOYMENT STATUS OR LIMITATIONS
11 ON SCOPE OF PARTICIPATION OF A HEALTH PROFESSIONAL UNDER
12 CONTRACT TO OR DIRECTLY EMPLOYED BY THE HEALTH MAINTENANCE ORGANIZATION,
13 INCLUDING AN OFFER BY THE HEALTH MAINTENANCE ORGANIZATION TO PERMIT
14 THE HEALTH PROFESSIONAL TO RESIGN INSTEAD OF THE HEALTH MAINTENANCE
15 ORGANIZATION TAKING DISCIPLINARY ACTION AGAINST THE HEALTH PROFESSIONAL.
16 THE NOTICE SHALL CONTAIN A SUMMARY OF THE INFORMATION PERTINENT TO THE
17 CHANGE AND SHALL BE TRANSMITTED IN WRITING TO THE APPROPRIATE BOARD
18 WITHIN 30 DAYS AFTER THE CHANGE OCCURS. AS USED IN THIS SECTION, "BOARD"
19 MEANS A LICENSING BOARD CREATED UNDER ARTICLE 15 OF THE PUBLIC HEALTH
20 CODE, 1978 PA 368, MCL 333.16101 TO 333.18838.

22 SEC. 3551. (1) A HEALTH MAINTENANCE ORGANIZATION'S MINIMUM
23 NET WORTH SHALL BE DETERMINED USING ACCOUNTING PROCEDURES
24 APPROVED BY THE COMMISSIONER THAT ENSURE THAT A HEALTH MAINTENANCE
25 ORGANIZATION IS FINANCIALLY AND ACTUARIALLY SOUND.

26 (2) A HEALTH MAINTENANCE ORGANIZATION LICENSED UNDER FORMER
27 PART 210 OF THE PUBLIC HEALTH CODE, 1978 PA 368, ON THE EFFECTIVE

1 DATE OF THIS CHAPTER THAT AUTOMATICALLY RECEIVED A CERTIFICATE OF
2 AUTHORITY UNDER SECTION 3505(1) SHALL POSSESS AND MAINTAIN UNIM-
3 PAIRED NET WORTH AS REQUIRED UNDER FORMER SECTION 21034 OF THE
4 PUBLIC HEALTH CODE, 1978 PA 368, UNTIL THE EARLIER OF THE
5 FOLLOWING:

6 (A) THE HEALTH MAINTENANCE ORGANIZATION ATTAINS A LEVEL OF
7 NET WORTH AS PROVIDED IN SUBSECTION (3) AT WHICH TIME THE HEALTH
8 MAINTENANCE ORGANIZATION SHALL CONTINUE TO MAINTAIN THAT LEVEL OF
9 NET WORTH.

10 (B) DECEMBER 31, 2003.

11 (3) A HEALTH MAINTENANCE ORGANIZATION APPLYING FOR A CERTIF-
12 ICATE OF AUTHORITY ON OR AFTER THE EFFECTIVE DATE OF THIS CHAPTER
13 AND A HEALTH MAINTENANCE ORGANIZATION WISHING TO MAINTAIN A CER-
14 TIFICATE OF AUTHORITY IN THIS STATE AFTER DECEMBER 31, 2003 SHALL
15 POSSESS AND MAINTAIN UNIMPAIRED NET WORTH IN AN AMOUNT DETERMINED
16 ADEQUATE BY THE COMMISSIONER TO CONTINUE TO COMPLY WITH
17 SECTION 403 BUT NOT LESS THAN THE FOLLOWING:

18 (A) FOR A HEALTH MAINTENANCE ORGANIZATION THAT CONTRACTS OR
19 EMPLOYS PROVIDERS IN NUMBERS SUFFICIENT TO PROVIDE 90% OF THE
20 HEALTH MAINTENANCE ORGANIZATION'S BENEFIT PAYOUT, MINIMUM NET
21 WORTH IS THE GREATEST OF THE FOLLOWING:

22 (i) \$1,500,000.00.

23 (ii) FOUR PERCENT OF THE HEALTH MAINTENANCE ORGANIZATION'S
24 SUBSCRIPTION REVENUE.

25 (iii) THREE MONTHS' UNCOVERED EXPENDITURES.

26 (B) FOR A HEALTH MAINTENANCE ORGANIZATION THAT DOES NOT
27 CONTRACT OR EMPLOY PROVIDERS IN NUMBERS SUFFICIENT TO PROVIDE 90%

1 OF THE HEALTH MAINTENANCE ORGANIZATION'S BENEFIT PAYOUT, MINIMUM
2 NET WORTH IS THE GREATEST OF THE FOLLOWING:

3 (i) \$3,000,000.00.

4 (ii) TEN PERCENT OF THE HEALTH MAINTENANCE ORGANIZATION'S
5 SUBSCRIPTION REVENUE.

6 (iii) THREE MONTHS' UNCOVERED EXPENDITURES.

7 (4) THE COMMISSIONER SHALL TAKE INTO ACCOUNT THE RISK-BASED
8 CAPITAL REQUIREMENTS AS DEVELOPED BY THE NATIONAL ASSOCIATION OF
9 INSURANCE COMMISSIONERS IN ORDER TO DETERMINE ADEQUATE COMPLIANCE
10 WITH SECTION 403 UNDER THIS SECTION.

11 SEC. 3553. (1) MINIMUM DEPOSIT REQUIREMENTS FOR A HEALTH
12 MAINTENANCE ORGANIZATION SHALL BE DETERMINED AS PROVIDED UNDER
13 THIS SECTION AND USING ACCOUNTING PROCEDURES APPROVED BY THE COM-
14 MISSIONER THAT ENSURE THAT A HEALTH MAINTENANCE ORGANIZATION IS
15 FINANCIALLY AND ACTUARIALLY SOUND.

16 (2) A HEALTH MAINTENANCE ORGANIZATION LICENSED UNDER FORMER
17 PART 210 OF THE PUBLIC HEALTH CODE, 1978 PA 368, ON THE EFFECTIVE
18 DATE OF THIS CHAPTER THAT AUTOMATICALLY RECEIVED A CERTIFICATE OF
19 AUTHORITY UNDER SECTION 3505(1) SHALL POSSESS AND MAINTAIN A
20 DEPOSIT AS REQUIRED UNDER FORMER SECTION 21034 OF THE PUBLIC
21 HEALTH CODE, 1978 PA 368, UNTIL THE EARLIER OF THE FOLLOWING:

22 (A) THE HEALTH MAINTENANCE ORGANIZATION ATTAINS THE LEVEL OF
23 DEPOSIT AS PROVIDED IN SUBSECTION (3) AT WHICH TIME THE HEALTH
24 MAINTENANCE ORGANIZATION SHALL CONTINUE TO MAINTAIN THAT LEVEL OF
25 DEPOSIT.

26 (B) DECEMBER 31, 2001.

1 (3) A HEALTH MAINTENANCE ORGANIZATION APPLYING FOR A
2 CERTIFICATE OF AUTHORITY ON OR AFTER THE EFFECTIVE DATE OF THIS
3 CHAPTER AND A HEALTH MAINTENANCE ORGANIZATION WISHING TO MAINTAIN
4 A CERTIFICATE OF AUTHORITY IN THIS STATE AFTER DECEMBER 31, 2001
5 SHALL POSSESS AND MAINTAIN A DEPOSIT IN AN AMOUNT DETERMINED ADE-
6 QUATE BY THE COMMISSIONER TO CONTINUE TO COMPLY WITH SECTION 403
7 BUT NOT LESS THAN \$100,000.00 PLUS 5% OF ANNUAL SUBSCRIPTION REV-
8 ENUE UP TO A \$1,000,000.00 MAXIMUM DEPOSIT.

9 (4) THE DEPOSIT REQUIRED UNDER THIS SECTION SHALL BE MADE
10 WITH THE STATE TREASURER OR WITH A FEDERAL OR STATE CHARTERED
11 FINANCIAL INSTITUTION UNDER A TRUST INDENTURE ACCEPTABLE TO THE
12 COMMISSIONER FOR THE SOLE BENEFIT OF THE SUBSCRIBERS AND ENROLL-
13 EES IN CASE OF INSOLVENCY.

14 SEC. 3555. A HEALTH MAINTENANCE ORGANIZATION SHALL MAINTAIN
15 A FINANCIAL PLAN EVALUATING, AT A MINIMUM, CASH FLOW NEEDS AND
16 ADEQUACY OF WORKING CAPITAL. THE PLAN SHALL DO ALL OF THE
17 FOLLOWING:

18 (A) DEMONSTRATE COMPLIANCE WITH ALL HEALTH MAINTENANCE
19 ORGANIZATION FINANCIAL REQUIREMENTS PROVIDED FOR IN THIS
20 CHAPTER.

21 (B) PROVIDE FOR ADEQUATE WORKING CAPITAL, WHICH SHALL NOT BE
22 NEGATIVE AT ANY TIME. THE COMMISSIONER MAY ESTABLISH A MINIMUM
23 WORKING CAPITAL REQUIREMENT FOR A HEALTH MAINTENANCE ORGANIZATION
24 TO ENSURE THE PROMPT PAYMENT OF LIABILITIES.

25 (C) IDENTIFY THE MEANS OF ACHIEVING AND MAINTAINING A POSI-
26 TIVE CASH FLOW, INCLUDING PROVISIONS FOR RETIREMENT OF EXISTING
27 OR PROPOSED INDEBTEDNESS.

1 SEC. 3557. A HEALTH MAINTENANCE ORGANIZATION SHALL FILE
2 NOTICE WITH THE COMMISSIONER OF ANY SUBSTANTIVE CHANGES IN OPERA-
3 TIONS NO LATER THAN 30 DAYS AFTER THE SUBSTANTIVE CHANGE IN
4 OPERATIONS. A SUBSTANTIVE CHANGE IN OPERATIONS INCLUDES, BUT IS
5 NOT LIMITED TO, ANY OF THE FOLLOWING:

6 (A) A CHANGE IN THE HEALTH MAINTENANCE ORGANIZATION'S OFFI-
7 CERS OR DIRECTORS. IN ADDITION TO THE NOTIFICATION, THE HEALTH
8 MAINTENANCE ORGANIZATION SHALL FILE A DISCLOSURE STATEMENT ON A
9 FORM PRESCRIBED BY THE COMMISSIONER FOR EACH NEWLY APPOINTED OR
10 ELECTED OFFICER OR DIRECTOR.

11 (B) A CHANGE IN THE LOCATION OF CORPORATE OFFICES.

12 (C) A CHANGE IN THE ORGANIZATION'S ARTICLES OF INCORPORATION
13 OR BYLAWS. A COPY OF THE REVISED ARTICLES OF INCORPORATION OR
14 BYLAWS SHALL BE INCLUDED WITH THE NOTICE.

15 (D) A CHANGE IN CONTRACTUAL ARRANGEMENTS UNDER WHICH THE
16 HEALTH MAINTENANCE ORGANIZATION IS MANAGED.

17 (E) ANY OTHER SIGNIFICANT CHANGE IN OPERATIONS.

18 SEC. 3559. (1) SUBJECT TO SUBSECTION (2), A HEALTH MAINTENANCE
19 ORGANIZATION SHALL OBTAIN A REINSURANCE CONTRACT OR ESTAB-
20 LISH A PLAN OF SELF-INSURANCE AS MAY BE NECESSARY TO ENSURE SOL-
21 VENCY OR TO PROTECT SUBSCRIBERS IN THE EVENT OF INSOLVENCY. A
22 REINSURANCE CONTRACT SHALL BE WITH AN INSURER THAT IS AUTHORIZED
23 OR ELIGIBLE TO TRANSACT INSURANCE IN MICHIGAN.

24 (2) A REINSURANCE CONTRACT OR PLAN UNDER SUBSECTION (1)
25 SHALL BE FILED FOR APPROVAL WITH THE COMMISSIONER NOT LATER THAN
26 30 DAYS AFTER THE FINALIZATION OF THE CONTRACT OR PLAN. A
27 REINSURANCE CONTRACT OR PLAN SHALL CLEARLY STATE ALL SERVICES TO

1 BE RECEIVED BY THE HEALTH MAINTENANCE ORGANIZATION. A
2 REINSURANCE CONTRACT OR PLAN SHALL BE CONSIDERED APPROVED 30 DAYS
3 AFTER IT IS FILED WITH THE COMMISSIONER UNLESS DISAPPROVED IN
4 WRITING BY THE COMMISSIONER BEFORE THE EXPIRATION OF THOSE 30
5 DAYS.

6 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL MAINTAIN INSUR-
7 ANCE COVERAGE TO PROTECT THE HEALTH MAINTENANCE ORGANIZATION THAT
8 INCLUDES, AT A MINIMUM, FIRE, THEFT, FIDELITY, GENERAL LIABILITY,
9 ERRORS AND OMISSIONS, DIRECTOR'S AND OFFICER'S LIABILITY COVER-
10 AGE, AND MALPRACTICE INSURANCE. A HEALTH MAINTENANCE ORGANIZA-
11 TION SHALL OBTAIN THE COMMISSIONER'S PRIOR APPROVAL BEFORE
12 SELF-INSURING FOR THESE COVERAGES.

13 SEC. 3561. A HEALTH MAINTENANCE ORGANIZATION SHALL HAVE A
14 PLAN FOR HANDLING INSOLVENCY THAT ALLOWS FOR CONTINUATION OF BEN-
15 EFITS FOR THE DURATION OF THE CONTRACT PERIOD FOR WHICH PREMIUMS
16 HAVE BEEN PAID AND CONTINUATION OF BENEFITS TO ANY MEMBER WHO IS
17 CONFINED ON THE DATE OF INSOLVENCY IN AN INPATIENT FACILITY UNTIL
18 HIS OR HER DISCHARGE FROM THAT FACILITY. CONTINUATION OF BENE-
19 FITS IN THE EVENT OF INSOLVENCY IS SATISFIED IF THE HEALTH MAIN-
20 TENANCE ORGANIZATION HAS AT LEAST 1 OF THE FOLLOWING, AS APPROVED
21 BY THE COMMISSIONER:

22 (A) A FINANCIAL GUARANTEE CONTRACT INSURED BY A SURETY BOND
23 ISSUED BY AN INDEPENDENT INSURER WITH A SECURE RATING FROM A
24 RATING AGENCY THAT MEETS THE REQUIREMENTS OF SECTION 436A(1)(P).

25 (B) A REINSURANCE CONTRACT ISSUED BY AN AUTHORIZED OR ELIGI-
26 BLE INSURER TO COVER THE EXPENSES TO BE PAID FOR CONTINUED
27 BENEFITS AFTER AN INSOLVENCY.

1 (C) A CONTRACT BETWEEN THE HEALTH MAINTENANCE ORGANIZATION
2 AND ITS AFFILIATED PROVIDERS THAT PROVIDES FOR THE CONTINUATION
3 OF PROVIDER SERVICES IN THE EVENT OF THE HEALTH MAINTENANCE
4 ORGANIZATION'S INSOLVENCY. [A CONTRACT UNDER THIS SUBDIVISION SHALL
PROVIDE A MECHANISM FOR APPROPRIATE SHARING BY THE HEALTH
MAINTENANCE ORGANIZATION OF THE CONTINUATION OF PROVIDER SERVICES AS
APPROVED BY THE COMMISSIONER AND SHALL NOT PROVIDE THAT CONTINUATION
OF PROVIDER SERVICES IS SOLELY THE RESPONSIBILITY OF THE AFFILIATED
PROVIDERS.]

5 (D) AN IRREVOCABLE LETTER OF CREDIT.

6 (E) AN INSOLVENCY RESERVE ACCOUNT ESTABLISHED WITH A FEDERAL
7 OR STATE CHARTERED FINANCIAL INSTITUTION UNDER A TRUST INDENTURE
8 ACCEPTABLE TO THE COMMISSIONER FOR THE SOLE BENEFIT OF SUBSCRIB-
9 ERS AND ENROLLEES, EQUAL TO 3 MONTHS' PREMIUM INCOME.

10 SEC. 3563. (1) IF A HEALTH MAINTENANCE ORGANIZATION BECOMES
11 INSOLVENT, UPON THE COMMISSIONER'S ORDER ALL OTHER HEALTH MAINTENANCE
12 ORGANIZATIONS AND HEALTH INSURERS THAT PARTICIPATED IN THE
13 ENROLLMENT PROCESS WITH THE INSOLVENT HEALTH MAINTENANCE ORGANI-
14 ZATION AT A GROUP'S LAST REGULAR ENROLLMENT PERIOD SHALL OFFER
15 THE INSOLVENT HEALTH MAINTENANCE ORGANIZATION'S AND HEALTH
16 INSURER'S GROUP ENROLLEES A 30-DAY ENROLLMENT PERIOD BEGINNING ON
17 THE DATE OF THE COMMISSIONER'S ORDER. EACH HEALTH MAINTENANCE
18 ORGANIZATION AND HEALTH INSURER SHALL OFFER THE INSOLVENT HEALTH
19 MAINTENANCE ORGANIZATION'S ENROLLEES THE SAME COVERAGES AND RATES
20 THAT IT HAD OFFERED TO THE ENROLLEES OF THE GROUP AT ITS LAST
21 REGULAR ENROLLMENT PERIOD.

22 (2) IF NO OTHER HEALTH MAINTENANCE ORGANIZATION OR HEALTH
23 INSURER HAD BEEN OFFERED TO SOME GROUPS ENROLLED IN THE INSOLVENT
24 HEALTH MAINTENANCE ORGANIZATION, OR IF THE COMMISSIONER DETER-
25 MINES THAT THE OTHER HEALTH MAINTENANCE ORGANIZATIONS OR HEALTH
26 INSURERS LACK SUFFICIENT HEALTH CARE DELIVERY RESOURCES TO ASSURE
27 THAT HEALTH CARE SERVICES WILL BE AVAILABLE AND ACCESSIBLE TO ALL

1 OF THE GROUP ENROLLEES OF THE INSOLVENT HEALTH MAINTENANCE
2 ORGANIZATION, THEN THE COMMISSIONER SHALL ALLOCATE EQUITABLY THE
3 INSOLVENT HEALTH MAINTENANCE ORGANIZATION'S GROUP CONTRACTS FOR
4 THESE GROUPS AMONG ALL HEALTH MAINTENANCE ORGANIZATIONS THAT
5 OPERATE WITHIN A PORTION OF THE INSOLVENT HEALTH MAINTENANCE
6 ORGANIZATION'S SERVICE AREA, TAKING INTO CONSIDERATION THE HEALTH
7 CARE DELIVERY RESOURCES OF EACH HEALTH MAINTENANCE ORGANIZATION.
8 EACH HEALTH MAINTENANCE ORGANIZATION TO WHICH A GROUP OR GROUPS
9 ARE SO ALLOCATED SHALL OFFER THE GROUP OR GROUPS THE HEALTH MAIN-
10 TENANCE ORGANIZATION'S EXISTING COVERAGE THAT IS MOST SIMILAR TO
11 EACH GROUP'S COVERAGE WITH THE INSOLVENT HEALTH MAINTENANCE
12 ORGANIZATION AT RATES DETERMINED IN ACCORDANCE WITH THE SUCCESSOR
13 HEALTH MAINTENANCE ORGANIZATION'S EXISTING RATING METHODOLOGY.

14 (3) THE COMMISSIONER SHALL ALLOCATE EQUITABLY THE INSOLVENT
15 HEALTH MAINTENANCE ORGANIZATION'S NONGROUP ENROLLEES WHO ARE
16 UNABLE TO OBTAIN OTHER COVERAGE AMONG ALL HEALTH MAINTENANCE
17 ORGANIZATIONS THAT OPERATE WITHIN A PORTION OF THE INSOLVENT
18 HEALTH MAINTENANCE ORGANIZATION'S SERVICE AREA, TAKING INTO CON-
19 sideration THE HEALTH CARE DELIVERY RESOURCES OF EACH HEALTH
20 MAINTENANCE ORGANIZATION. EACH HEALTH MAINTENANCE ORGANIZATION
21 TO WHICH NONGROUP ENROLLEES ARE ALLOCATED SHALL OFFER THE NON-
22 GROUP ENROLLEES THE HEALTH MAINTENANCE ORGANIZATION'S EXISTING
23 COVERAGE WITHOUT A PREEXISTING CONDITION LIMITATION FOR INDIVID-
24 UAL OR CONVERSION COVERAGE AS DETERMINED BY THE ENROLLEE'S TYPE
25 OF COVERAGE IN THE INSOLVENT HEALTH MAINTENANCE ORGANIZATION AT
26 RATES DETERMINED IN ACCORDANCE WITH THE SUCCESSOR HEALTH
27 MAINTENANCE ORGANIZATION'S EXISTING RATING METHODOLOGY.

1 SUCCESSOR HEALTH MAINTENANCE ORGANIZATIONS THAT DO NOT OFFER
2 DIRECT NONGROUP ENROLLMENT MAY AGGREGATE ALL OF THE ALLOCATED
3 NONGROUP ENROLLEES INTO 1 GROUP FOR RATING AND COVERAGE
4 PURPOSES.

5 (4) IF A HEALTH MAINTENANCE ORGANIZATION THAT CONTRACTS WITH
6 A STATE FUNDED HEALTH CARE PROGRAM BECOMES INSOLVENT, THE COMMIS-
7 SIONER SHALL INFORM THE STATE AGENCY RESPONSIBLE FOR THE PROGRAM
8 OF THE INSOLVENCY. NOTWITHSTANDING ANY OTHER PROVISION OF THIS
9 SECTION, ENROLLEES OF AN INSOLVENT HEALTH MAINTENANCE ORGANIZA-
10 TION COVERED BY A STATE FUNDED HEALTH CARE PROGRAM MAY BE REAS-
11 SIGNED IN ACCORDANCE WITH STATE AND FEDERAL STATUTES GOVERNING
12 THE PARTICULAR PROGRAM.

13 SEC. 3565. (1) A NONGROUP SUBSCRIBER, IN ADDITION TO OTHER
14 RIGHTS AVAILABLE TO REVOKE AN OFFER, MAY CANCEL A HEALTH MAINTENANCE
15 CONTRACT WITHIN 72 HOURS AFTER SIGNING. ANY DEPOSIT OR
16 PREPAYMENT MADE SHALL BE REFUNDED WITHIN 30 DAYS OF RECEIPT OF
17 THE NOTICE OF CANCELLATION. A NONGROUP SUBSCRIBER SHALL BE
18 RESPONSIBLE FOR PAYMENT OF REASONABLE FEES FOR ANY SERVICES
19 RECEIVED DURING THE 72 HOURS. FEES MAY BE DEDUCTED FROM THE
20 DEPOSIT OR PREPAYMENT BEFORE THE REFUND IS MADE.

21 (2) CANCELLATION SHALL OCCUR WHEN WRITTEN NOTICE OF CANCEL-
22 LATION IS MAILED OR HAND-DELIVERED TO THE ORGANIZATION OR ITS
23 AGENT OR REPRESENTATIVE.

24 (3) NOTICE OF CANCELLATION SHALL BE SUFFICIENT IF IT INDI-
25 CATES THE INTENTION OF THE PERSON NOT TO BE BOUND BY THE CONTRACT
26 OR APPLICATION.

1 (4) THE RIGHT OF CANCELLATION SHALL APPEAR IN BOLDFACED TYPE
2 ON THE SAME PAGE THE INDIVIDUAL SUBSCRIBER SIGNS TO BIND THE
3 CONTRACT.

4 SEC. 3567. (1) A HEALTH MAINTENANCE CONTRACT SHALL CLEARLY
5 DELINEATE ALL CONDITIONS UNDER WHICH THE HEALTH MAINTENANCE
6 ORGANIZATION MAY CANCEL COVERAGE FOR AN ENROLLEE.

7 (2) A HEALTH MAINTENANCE CONTRACT FOR NONGROUP SUBSCRIBERS
8 SHALL SPECIFY AN ENROLLEE'S RIGHTS AND OPTIONS IN THE CASE OF A
9 PROPOSED AMENDMENT OR CHANGE IN THE CONTRACT OR THE RATE
10 CHARGED.

11 (3) CONTINUED PREPAYMENT BY THE SUBSCRIBER DURING THE PERIOD
12 OF APPEAL, AND WHILE AN APPEAL IS IN PROGRESS, DOES NOT CONSTI-
13 TUTE ACCEPTANCE OF THE PROPOSED AMENDMENT OR RATE CHANGE.

14 SEC. 3569. (1) EXCEPT AS PROVIDED IN SECTION 3515(2), A
15 HEALTH MAINTENANCE ORGANIZATION SHALL ASSUME FULL FINANCIAL RISK
16 ON A PROSPECTIVE BASIS FOR THE PROVISION OF HEALTH MAINTENANCE
17 SERVICES. HOWEVER, THE ORGANIZATION MAY DO ANY OF THE
18 FOLLOWING:

19 (A) REQUIRE AN AFFILIATED PROVIDER TO ASSUME FINANCIAL RISK
20 UNDER THE TERMS OF ITS CONTRACT.

21 (B) OBTAIN INSURANCE.

22 (C) MAKE OTHER ARRANGEMENTS FOR THE COST OF PROVIDING TO AN
23 ENROLLEE HEALTH MAINTENANCE SERVICES THE AGGREGATE VALUE OF WHICH
24 IS MORE THAN \$5,000.00 IN A YEAR FOR THAT ENROLLEE.

25 (2) IF THE HEALTH MAINTENANCE ORGANIZATION REQUIRES AN
26 AFFILIATED PROVIDER TO ASSUME FINANCIAL RISK UNDER THE TERMS OF
27 ITS CONTRACT, THE CONTRACT SHALL REQUIRE BOTH OF THE FOLLOWING:

1 (A) THE HEALTH MAINTENANCE ORGANIZATION TO PAY THE
2 AFFILIATED PROVIDER, INCLUDING A SUBCONTRACTED PROVIDER, DIRECTLY
3 OR THROUGH A LICENSED THIRD PARTY ADMINISTRATOR FOR HEALTH MAIN-
4 TENANCE SERVICES PROVIDED TO ITS ENROLLEES.

5 (B) THE HEALTH MAINTENANCE ORGANIZATION TO KEEP ALL POOLED
6 FUNDS AND WITHHOLD AMOUNTS AND ACCOUNT FOR THEM ON ITS FINANCIAL
7 BOOKS AND RECORDS AND RECONCILE THEM AT YEAR END IN ACCORDANCE
8 WITH THE WRITTEN AGREEMENT BETWEEN THE AFFILIATED PROVIDER AND
9 THE HEALTH MAINTENANCE ORGANIZATION.

10 (3) AS USED IN THIS SECTION, "REQUIRING AN AFFILIATED PRO-
11 VIDER TO ASSUME FINANCIAL RISK" MEANS A TRANSACTION WHEREBY A
12 PORTION OF THE CHANCE OF LOSS, INCLUDING EXPENSES INCURRED,
13 RELATED TO THE DELIVERY OF HEALTH MAINTENANCE SERVICES IS SHARED
14 WITH AN AFFILIATED PROVIDER IN RETURN FOR A CONSIDERATION. THESE
15 TRANSACTIONS INCLUDE, BUT ARE NOT LIMITED TO, FULL OR PARTIAL
16 CAPITATION AGREEMENTS, WITHHOLDS, RISK CORRIDORS, AND INDEMNITY
17 AGREEMENTS.

18 SEC. 3571. A HEALTH MAINTENANCE ORGANIZATION IS NOT PRE-
19 CLUDED FROM MEETING THE REQUIREMENTS OF, RECEIVING MONEYS FROM,
20 AND ENROLLING BENEFICIARIES OR RECIPIENTS OF, STATE AND FEDERAL
21 HEALTH PROGRAMS.

22 SEC. 3573. A PERSON PROPOSING TO OPERATE A SYSTEM OF HEALTH
23 CARE DELIVERY AND FINANCING THAT IS TO BE OFFERED TO INDIVIDUALS,
24 WHETHER OR NOT AS MEMBERS OF GROUPS, IN EXCHANGE FOR A FIXED PAY-
25 MENT AND ORGANIZED SO THAT PROVIDERS AND THE ORGANIZATION ARE IN
26 SOME PART AT RISK FOR THE COST OF SERVICES IN A MANNER SIMILAR TO
27 A HEALTH MAINTENANCE ORGANIZATION, BUT FAILS TO MEET THE

1 REQUIREMENTS SET FORTH IN THIS CHAPTER, MAY OPERATE SUCH A SYSTEM
2 IF THE COMMISSIONER FINDS THAT THE PROPOSED OPERATION WILL BENE-
3 FIT PERSONS WHO WILL BE SERVED BY IT. THE OPERATION SHALL BE
4 AUTHORIZED AND REGULATED IN THE SAME MANNER AS A HEALTH MAINTENANCE
5 ORGANIZATION UNDER THIS CHAPTER INCLUDING THE FILING OF
6 PERIODIC REPORTS, EXCEPT TO THE EXTENT THAT THE COMMISSIONER
7 FINDS THAT THE REGULATION IS INAPPROPRIATE TO THE SYSTEM OF
8 HEALTH CARE DELIVERY AND FINANCING. A PERSON OPERATING A SYSTEM
9 OF HEALTH CARE DELIVERY AND FINANCING UNDER THIS SECTION SHALL
10 NOT ADVERTISE OR SOLICIT OR IN ANY WAY IDENTIFY ITSELF IN A
11 MANNER IMPLYING TO THE PUBLIC THAT IT IS A HEALTH MAINTENANCE
12 ORGANIZATION AUTHORIZED UNDER THIS CHAPTER.

13 Enacting section 1. Part 210 of the public health code,
14 1978 PA 368, MCL 333.21001 to 333.21098, is repealed.