



HOUSE BILL No. 5575

April 12, 2000, Introduced by Reps. Van Woerkom, Caul, Rick Johnson, Patterson, Cameron Brown, Sanborn, Birkholz, Kuipers, Allen, Richardville, Shackleton, Bishop, Jelinek, Faunce, Voorhees, Kukuk, Scranton, LaSata, Law and Cassis and referred to the Committee on Health Policy.

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~~ AND A HEALTH MAINTENANCE ORGANIZATION
14 ARE subject to a regulatory fee instead of the costs and expenses
15 provided for in subsections (2) and (3). By June 30 of each year
16 or within 30 days after the enactment into law of any appropria-
17 tion for the insurance bureau's operation, the commissioner shall
18 impose upon all insurers AND HEALTH MAINTENANCE ORGANIZATIONS
19 authorized to do business in this state a regulatory fee calcu-
20 lated as follows:

21 (a) As used in this subsection:

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

24 (ii) "B" means base assessment rate. The base assessment
25 rate shall not exceed .00038 and shall be a fraction the numera-
26 tor of which is the total regulatory fee and the denominator of
27 which is the total amount of direct underwritten premiums written

1 in this state by all insurers for the immediately preceding
 2 calendar year as reported to the commissioner on the insurer's
 3 annual statements filed with the commissioner.

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

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

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

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

22 (b) Two actual assessment rates shall be calculated so as to
 23 distribute 75% of the burden of the regulatory fee shortfall cre-
 24 ated by the exclusion of annuity considerations from the assess-
 25 ment base to life insurance and 25% to all other insurance. The
 26 2 actual assessment rates shall be determined as follows:

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

1 L insurance.

2 (ii) $\frac{I \times B + .25 \times B \times A}{I}$ = assessment rate for insurance
3 other than life insurance.

4 (c) ~~Except as otherwise provided in subdivision (d), each~~
5 EACH insurer's regulatory fee shall be a minimum fee of \$250.00
6 and shall be determined by multiplying the actual assessment rate
7 by the assessment base of that insurer as determined by the com-
8 missioner from the insurer's annual statement for the immediately
9 preceding calendar year filed with the commissioner.

10 ~~(d) The total regulatory fee for all health maintenance~~
11 ~~organizations in this state shall be determined by multiplying~~
12 ~~the actual assessment rate by 70% of direct underwritten premiums~~
13 ~~written by all health maintenance organizations in this state for~~
14 ~~the immediately preceding calendar year as reported to the com-~~
15 ~~missioner in the health maintenance organization's annual state-~~
16 ~~ments filed with the commissioner. Each health maintenance~~
17 ~~organization's regulatory fee shall be a minimum fee of \$250.00~~
18 ~~and shall be determined by taking the total regulatory fee for~~
19 ~~all health maintenance organizations divided by the total number~~
20 ~~of members of all health maintenance organizations and multiply-~~
21 ~~ing this quotient by the number of members in the individual~~
22 ~~health maintenance organization.~~

23 (5) Not less than 67% of the revenue derived from the regu-
24 latory fee under subsection (4) shall be used for the regulation
25 of financial conduct of persons regulated under the
26 commissioner's authority and for the regulation of persons
27 regulated under the commissioner's authority engaged in the
28 business of health care and health insurance in this state.

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 to the insured OR
7 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 to the insured OR ENROLLEE of
12 the results of the insurer's OR HEALTH MAINTENANCE ORGANIZATION'S
13 investigation and for advisement of the insured's OR ENROLLEE'S
14 right to review the grievance by the commissioner THROUGH
15 SEPTEMBER 30, 2000 AND BEGINNING OCTOBER 1, 2000 BY AN INDEPEN-
16 DENT REVIEW ORGANIZATION UNDER THE PATIENT'S RIGHT TO INDEPENDENT
17 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 containing the reasons for the adverse determination
5 ~~will be~~ IS provided to the insured ~~person.~~ (k) ~~That~~ OR
6 ENROLLEE ALONG WITH a written notification IN PLAIN ENGLISH of
7 the ~~grievance procedures will be provided to the insured person~~
8 ~~when the insured person contests an adverse determination~~ RIGHT
9 TO A REVIEW BY THE COMMISSIONER THROUGH SEPTEMBER 30, 2000 AND
10 BEGINNING OCTOBER 1, 2000 BY AN INDEPENDENT REVIEW ORGANIZATION
11 UNDER THE PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT.

12 (K) ~~(l)~~ That a final determination will be made in writing
13 by the insurer OR HEALTH MAINTENANCE ORGANIZATION not later than
14 ~~90~~ 45 calendar days after a formal grievance is submitted in
15 writing by the insured ~~person~~ OR ENROLLEE. The timing for the
16 ~~90-calendar-day~~ 45-CALENDAR-DAY period may be tolled, however,
17 for any period of time the insured ~~person~~ OR ENROLLEE is per-
18 mitted to take under the grievance procedure.

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

1 SEPTEMBER 30, 2000 AND BEGINNING OCTOBER 1, 2000 BY AN
2 INDEPENDENT REVIEW ORGANIZATION UNDER THE PATIENT'S RIGHT TO
3 INDEPENDENT REVIEW ACT. If further review is requested, a final
4 determination by the insurer OR HEALTH MAINTENANCE ORGANIZATION
5 shall be made not later than 30 days after receipt of the request
6 for further review. Within 10 days after receipt of a final
7 determination, the insured or ~~a person, including, but not~~
8 ~~limited to, a physician, authorized in writing to act on behalf~~
9 ~~of the insured~~ ENROLLEE may request a determination of the
10 matter by the commissioner or his or her designee THROUGH
11 SEPTEMBER 30, 2000 AND BEGINNING OCTOBER 1, 2000 BY AN INDEPEN-
12 DENT REVIEW ORGANIZATION UNDER THE PATIENT'S RIGHT TO INDEPENDENT
13 REVIEW ACT. If the initial or final determination by the insurer
14 OR HEALTH MAINTENANCE ORGANIZATION is made orally, the insurer OR
15 HEALTH MAINTENANCE ORGANIZATION shall provide a written confirma-
16 tion of the determination to the insured OR ENROLLEE not later
17 than 2 business days after the oral determination. An expedited
18 grievance under this subdivision applies if a grievance is sub-
19 mitted and a physician, orally or in writing, substantiates that
20 the time frame for a grievance under subdivision ~~(t)~~ (K) would
21 acutely jeopardize the life of the insured OR ENROLLEE.
22 (M) ~~(n)~~ That the insured ~~person~~ OR ENROLLEE has the
23 right to a determination of the matter by the commissioner or his
24 or her designee THROUGH SEPTEMBER 30, 2000 AND BEGINNING OCTOBER
25 1, 2000 BY AN INDEPENDENT REVIEW ORGANIZATION UNDER THE PATIENT'S
26 RIGHT TO INDEPENDENT REVIEW ACT.

~~1 (2) The commissioner shall establish a procedure for a
2 determination of a grievance under this section which shall be
3 reasonably calculated to resolve these matters informally and as
4 rapidly as possible, while protecting the interests of both the
5 insured and the insurer. This procedure is not a contested case
6 under the administrative procedures act of 1969, Act No. 306 of
7 the Public Acts of 1969, being sections 24.201 to 24.328 of the
8 Michigan Compiled Laws, and is not appealable under Act No. 306
9 of the Public Acts of 1969.~~

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

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

17 (4) As used in this section:

18 (a) "Adverse determination" means a determination that an
19 admission, availability of care, continued stay, or other health
20 care service has been reviewed and denied. Failure to respond in
21 a timely manner to a request for a determination constitutes an
22 adverse determination.

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

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

4 (ii) Benefits or claims payment, handling, or reimbursement
5 for health care services.

6 (iii) Matters pertaining to the contractual relationship
7 between an insured OR ENROLLEE and the insurer OR HEALTH MAINTENANCE ORGANIZATION.
8

9 CHAPTER 35

10 HEALTH MAINTENANCE ORGANIZATIONS

11 SEC. 3501. AS USED IN THIS CHAPTER:

12 (A) "AFFILIATED PROVIDER" MEANS A HEALTH PROFESSIONAL,
13 LICENSED HOSPITAL, LICENSED PHARMACY, OR ANY OTHER INSTITUTION,
14 ORGANIZATION, OR PERSON HAVING A CONTRACT WITH A HEALTH MAINTENANCE ORGANIZATION TO RENDER 1 OR MORE HEALTH MAINTENANCE SERVICES TO AN ENROLLEE.
15
16

17 (B) "BASIC HEALTH SERVICES" MEANS:

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

20 (ii) AMBULATORY SERVICES.

21 (iii) INPATIENT HOSPITAL SERVICES, OTHER THAN THOSE FOR THE
22 TREATMENT OF MENTAL ILLNESS.

23 (iv) EMERGENCY HEALTH SERVICES.

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

26 (vi) INTERMEDIATE AND OUTPATIENT CARE FOR SUBSTANCE ABUSE AS
27 FOLLOWS:

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

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

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

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

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

4 (vii) DIAGNOSTIC LABORATORY AND DIAGNOSTIC AND THERAPEUTIC
5 RADIOLOGICAL SERVICES.

6 (viii) HOME HEALTH SERVICES.

7 (ix) PREVENTIVE HEALTH SERVICES.

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

11 (D) "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 (E) "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 (F) "HEALTH MAINTENANCE SERVICES" MEANS SERVICES PROVIDED TO
2 ENROLLEES OF A HEALTH MAINTENANCE ORGANIZATION UNDER THEIR HEALTH
3 MAINTENANCE CONTRACT.

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

13 (I) "SERVICE AREA" MEANS A DEFINED GEOGRAPHICAL AREA IN
14 WHICH HEALTH MAINTENANCE SERVICES ARE GENERALLY AVAILABLE AND
15 READILY ACCESSIBLE TO ENROLLEES AND WHERE HEALTH MAINTENANCE
16 ORGANIZATIONS MAY MARKET THEIR CONTRACTS.

17 (J) "SUBSCRIBER" MEANS AN INDIVIDUAL WHO ENTERS INTO A
18 HEALTH MAINTENANCE CONTRACT, OR ON WHOSE BEHALF A HEALTH MAINTENANCE
19 CONTRACT IS ENTERED INTO, WITH A HEALTH MAINTENANCE ORGANI-
20 ZATION THAT HAS RECEIVED A CERTIFICATE OF AUTHORITY UNDER THIS
21 CHAPTER AND TO WHOM A HEALTH MAINTENANCE CONTRACT IS ISSUED.

22 SEC. 3503. (1) ALL OF THE PROVISIONS OF THIS ACT THAT APPLY
23 TO A DOMESTIC INSURER AUTHORIZED TO ISSUE AN EXPENSE-INCURRED
24 HOSPITAL, MEDICAL, OR SURGICAL POLICY OR CERTIFICATE, INCLUDING,
25 BUT NOT LIMITED TO, SECTION 223 AND CHAPTERS 34 AND 36, APPLY TO
26 A HEALTH MAINTENANCE ORGANIZATION UNDER THIS CHAPTER UNLESS

1 SPECIFICALLY EXCLUDED, OR OTHERWISE SPECIFICALLY PROVIDED FOR IN
2 THIS CHAPTER.

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

5 SEC. 3505. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL
6 RECEIVE A CERTIFICATE OF AUTHORITY UNDER THIS CHAPTER BEFORE
7 ISSUING HEALTH MAINTENANCE CONTRACTS. A HEALTH MAINTENANCE
8 ORGANIZATION LICENSE ISSUED UNDER FORMER PART 210 OF THE PUBLIC
9 HEALTH CODE, 1978 PA 368, AUTOMATICALLY BECOMES A CERTIFICATE OF
10 AUTHORITY UNDER THIS CHAPTER ON THE EFFECTIVE DATE OF THIS
11 CHAPTER.

12 (2) "HEALTH MAINTENANCE ORGANIZATION" SHALL NOT BE USED TO
13 DESCRIBE OR REFER TO ANY ENTITY OR PERSON AND AN ENTITY OR PERSON
14 SHALL NOT USE ANY OTHER DESCRIPTIVE WORDS THAT MAY MISLEAD,
15 DECEIVE, OR IMPLY THAT IT IS A HEALTH MAINTENANCE ORGANIZATION,
16 UNLESS THE ENTITY OR PERSON HAS A CERTIFICATE OF AUTHORITY AS A
17 HEALTH MAINTENANCE ORGANIZATION UNDER THIS CHAPTER.

18 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL NOT USE IN ITS
19 NAME, CONTRACTS, OR LITERATURE THE WORDS "INSURANCE", "CASUALTY",
20 "SURETY", "MUTUAL", OR ANY OTHER WORDS DESCRIPTIVE OF AN INSUR-
21 ANCE, CASUALTY, OR SURETY BUSINESS OR DECEPTIVELY SIMILAR TO THE
22 NAME OR DESCRIPTION OF AN INSURANCE OR SURETY CORPORATION DOING
23 BUSINESS IN THIS STATE.

24 SEC. 3507. THE COMMISSIONER SHALL ESTABLISH A SYSTEM OF
25 AUTHORIZING AND REGULATING HEALTH MAINTENANCE ORGANIZATIONS IN
26 THIS STATE TO PROTECT AND PROMOTE THE PUBLIC HEALTH THROUGH THE
27 ASSURANCE THAT THE ORGANIZATIONS PROVIDE:

1 (A) AN ACCEPTABLE QUALITY OF HEALTH CARE BY QUALIFIED
2 PERSONNEL.

3 (B) HEALTH CARE FACILITIES, EQUIPMENT, AND PERSONNEL THAT
4 MAY REASONABLY BE REQUIRED TO ECONOMICALLY PROVIDE HEALTH MAINTENANCE
5 SERVICES.

6 (C) OPERATIONAL ARRANGEMENTS THAT INTEGRATE THE DELIVERY OF
7 VARIOUS SERVICES.

8 (D) A FINANCIALLY SOUND PREPAYMENT PLAN FOR MEETING HEALTH
9 CARE COSTS.

10 SEC. 3508. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL
11 DEVELOP AND MAINTAIN A QUALITY ASSESSMENT PROGRAM TO ASSESS THE
12 QUALITY OF HEALTH CARE PROVIDED TO ENROLLEES THAT INCLUDES, AT A
13 MINIMUM, SYSTEMATIC COLLECTION, ANALYSIS, AND REPORTING OF RELEVANT
14 DATA IN ACCORDANCE WITH STATUTORY AND REGULATORY
15 REQUIREMENTS. A HEALTH MAINTENANCE ORGANIZATION SHALL FILE ITS
16 QUALITY ASSESSMENT PROGRAM AS PRESCRIBED BY THE COMMISSIONER.

17 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL ESTABLISH AND
18 MAINTAIN A QUALITY IMPROVEMENT PROGRAM TO DESIGN, MEASURE,
19 ASSESS, AND IMPROVE THE PROCESSES AND OUTCOMES OF HEALTH CARE AS
20 IDENTIFIED IN THE PROGRAM. A HEALTH MAINTENANCE ORGANIZATION
21 SHALL FILE ITS QUALITY IMPROVEMENT PROGRAM AS PRESCRIBED BY THE
22 COMMISSIONER. THE QUALITY IMPROVEMENT PROGRAM SHALL BE UNDER THE
23 DIRECTION OF THE HEALTH MAINTENANCE ORGANIZATION'S MEDICAL DIRECTOR
24 AND SHALL INCLUDE:

25 (A) A WRITTEN STATEMENT OF THE PROGRAM'S OBJECTIVES, LINES
26 OF AUTHORITY AND ACCOUNTABILITY, EVALUATION TOOLS, INCLUDING DATA

1 COLLECTION RESPONSIBILITIES, AND PERFORMANCE IMPROVEMENT
2 ACTIVITIES.

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

4 (C) A WRITTEN QUALITY IMPROVEMENT PLAN THAT, AT A MINIMUM,
5 DESCRIBES HOW THE HEALTH MAINTENANCE ORGANIZATION ANALYZES BOTH
6 THE PROCESSES AND OUTCOMES OF CARE, IDENTIFIES THE TARGETED DIAG-
7 NOSES AND TREATMENTS TO BE REVIEWED EACH YEAR, USES A RANGE OF
8 APPROPRIATE METHODS TO ANALYZE QUALITY, COMPARES PROGRAM FINDINGS
9 WITH PAST PERFORMANCE AND INTERNAL GOALS AND EXTERNAL STANDARDS,
10 MEASURES THE PERFORMANCE OF AFFILIATED PROVIDERS, AND CONDUCTS
11 PEER REVIEW ACTIVITIES.

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

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

18 (3) A HEALTH MAINTENANCE ORGANIZATION SEEKING TO CHANGE THE
19 APPROVED SERVICE AREA SHALL SUBMIT AN APPLICATION TO CHANGE SERV-
20 ICE AREA TO THE COMMISSIONER AND SHALL NOT CHANGE THE SERVICE
21 AREA UNTIL APPROVAL IS RECEIVED. THE COMMISSIONER SHALL SPECIFY
22 THE INFORMATION REQUIRED TO BE IN THE APPLICATION UNDER THIS
23 SUBSECTION.

24 SEC. 3511. (1) BY THE END OF THE FIRST 12 MONTHS OF OPERA-
25 TION, A HEALTH MAINTENANCE ORGANIZATION'S GOVERNING BODY SHALL
26 HAVE A MINIMUM OF 1/3 OF ITS MEMBERSHIP CONSISTING OF ADULT
27 ENROLLEES OF THE ORGANIZATION WHO ARE NOT COMPENSATED OFFICERS,

1 EMPLOYEES, STOCKHOLDERS WHO OWN MORE THAN 5% OF THE
2 ORGANIZATION'S SHARES, OR OTHER INDIVIDUALS RESPONSIBLE FOR THE
3 CONDUCT OF, OR FINANCIALLY INTERESTED IN, THE ORGANIZATION'S
4 AFFAIRS. THE ENROLLEE BOARD MEMBERS SHALL BE ELECTED BY A SIMPLE
5 PLURALITY OF THE VOTING SUBSCRIBERS. EACH SUBSCRIBER SHALL HAVE
6 1 VOTE. THE ENROLLEE BOARD MEMBERS SHALL HOLD OFFICE FOR 3 YEARS
7 AFTER THEIR ELECTION, EXCEPT THAT THE TERMS OF OFFICE FOLLOWING
8 THE FIRST ENROLLEE ELECTION MAY BE ADJUSTED TO ALLOW THE TERMS OF
9 ENROLLEE BOARD MEMBERS TO EXPIRE ON A STAGGERED BASIS. A VACANCY
10 AMONG ENROLLEE BOARD MEMBERS SHALL BE FILLED BY APPOINTMENT BY A
11 SIMPLE MAJORITY OF THE REMAINING ENROLLEE MEMBERS OF THE BOARD
12 FROM INDIVIDUALS MEETING THE QUALIFICATIONS OF THIS SECTION. A
13 VACANCY SHALL BE FILLED ONLY FOR THE UNEXPIRED PORTION OF THE
14 ORIGINAL TERM, AT WHICH TIME THE ENROLLEE MEMBER SHALL BE ELECTED
15 IN THE MANNER PRESCRIBED BY THIS CHAPTER.

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

19 SEC. 3513. (1) THE COMMISSIONER SHALL REGULATE HEALTH
20 DELIVERY ASPECTS OF HEALTH MAINTENANCE ORGANIZATION OPERATIONS
21 FOR THE PURPOSE OF ASSURING THAT HEALTH MAINTENANCE ORGANIZATIONS
22 ARE CAPABLE OF PROVIDING CARE AND SERVICES PROMPTLY, APPROPRIATE-
23 LY, AND IN A MANNER THAT ASSURES CONTINUITY AND ACCEPTABLE QUAL-
24 ITY OF HEALTH CARE. THE COMMISSIONER SHALL ENCOURAGE HEALTH
25 MAINTENANCE ORGANIZATIONS TO UTILIZE A WIDE VARIETY OF
26 HEALTH-RELATED DISCIPLINES AND FACILITIES AND TO DEVELOP SERVICES

1 THAT CONTRIBUTE TO THE PREVENTION OF DISEASE AND DISABILITY AND
2 TO THE RESTORATION OF HEALTH.

3 (2) THE COMMISSIONER SHALL REGULATE THE BUSINESS AND FINAN-
4 CIAL ASPECTS OF HEALTH MAINTENANCE ORGANIZATION OPERATIONS FOR
5 THE PURPOSE OF ASSURING THAT THE ORGANIZATIONS ARE FINANCIALLY
6 SOUND AND FOLLOW ACCEPTABLE BUSINESS PRACTICES. THE COMMISSIONER
7 SHALL ASSURE THAT THE ORGANIZATIONS OPERATE IN THE INTEREST OF
8 ENROLLEES CONSISTENT WITH OVERALL HEALTH CARE COST CONTAINMENT
9 WHILE DELIVERING ACCEPTABLE QUALITY OF CARE AND SERVICES THAT ARE
10 AVAILABLE AND ACCESSIBLE TO ENROLLEES WITH APPROPRIATE ADMINIS-
11 TRATIVE COSTS AND HEALTH CARE PROVIDER INCENTIVES. A HEALTH
12 MAINTENANCE ORGANIZATION SHALL DO ALL OF THE FOLLOWING:

13 (A) PROVIDE, AS PROMPTLY AS APPROPRIATE, HEALTH MAINTENANCE
14 SERVICES IN A MANNER THAT ASSURES CONTINUITY AND IMPARTS QUALITY
15 HEALTH CARE UNDER CONDITIONS THE COMMISSIONER CONSIDERS TO BE IN
16 THE PUBLIC INTEREST.

17 (B) PROVIDE, WITHIN THE GEOGRAPHIC AREA SERVED BY THE HEALTH
18 MAINTENANCE ORGANIZATION, HEALTH MAINTENANCE SERVICES THAT ARE
19 AVAILABLE, ACCESSIBLE, AND PROVIDED AS PROMPTLY AS APPROPRIATE TO
20 EACH OF ITS ENROLLEES IN A MANNER THAT ASSURES CONTINUITY, AND
21 ARE AVAILABLE AND ACCESSIBLE TO ENROLLEES 24 HOURS A DAY AND 7
22 DAYS A WEEK FOR THE TREATMENT OF EMERGENCY EPISODES OF ILLNESS OR
23 INJURY.

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

26 (D) PROVIDE THAT REASONABLE PROVISIONS EXIST FOR AN ENROLLEE
27 TO OBTAIN EMERGENCY HEALTH SERVICES BOTH WITHIN AND OUTSIDE OF

1 THE GEOGRAPHIC AREA SERVED BY THE HEALTH MAINTENANCE
2 ORGANIZATION.

3 (E) PROVIDE THAT REASONABLE PROCEDURES EXIST FOR RESOLVING
4 ENROLLEE GRIEVANCES AS REQUIRED BY THIS CHAPTER OR AS OTHERWISE
5 PROVIDED BY LAW.

6 (F) BE INCORPORATED AS A DISTINCT LEGAL ENTITY UNDER THE
7 BUSINESS CORPORATION ACT, 1972 PA 284, MCL 450.1101 TO 450.2098,
8 THE NONPROFIT CORPORATION ACT, 1982 PA 162, MCL 450.2101 TO
9 450.3192, OR THE MICHIGAN LIMITED LIABILITY COMPANY ACT, 1993 PA
10 23, MCL 450.4101 TO 450.5200.

11 (G) HAVE A GOVERNING BODY THAT MEETS THE REQUIREMENTS OF
12 THIS CHAPTER.

13 SEC. 3515. (1) A HEALTH MAINTENANCE ORGANIZATION MAY PRO-
14 VIDE ADDITIONAL HEALTH MAINTENANCE SERVICES OR ANY OTHER RELATED
15 HEALTH CARE SERVICE OR TREATMENT NOT REQUIRED UNDER THIS
16 CHAPTER.

17 (2) A HEALTH MAINTENANCE ORGANIZATION MAY HAVE HEALTH MAIN-
18 TENANCE CONTRACTS WITH NOMINAL COPAYMENTS THAT ARE REQUIRED FOR
19 SPECIFIC HEALTH MAINTENANCE SERVICES. COPAYMENTS SHALL NOT
20 EXCEED 50% OF A HEALTH MAINTENANCE ORGANIZATION'S REIMBURSEMENT
21 TO AN AFFILIATED PROVIDER FOR PROVIDING THE SERVICE TO AN
22 ENROLLEE AND SHALL NOT BE BASED ON THE PROVIDER'S STANDARD CHARGE
23 FOR THE SERVICE.

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

1 SEC. 3517. (1) A HEALTH MAINTENANCE CONTRACT SHALL NOT
2 PROVIDE FOR PAYMENT OF CASH OR OTHER MATERIAL BENEFIT TO AN
3 ENROLLEE, EXCEPT AS STATED IN THIS CHAPTER.

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

15 SEC. 3519. (1) A HEALTH MAINTENANCE ORGANIZATION CONTRACT
16 AND THE CONTRACT'S RATES, INCLUDING ANY NOMINAL COPAYMENTS,
17 BETWEEN THE ORGANIZATION AND ITS SUBSCRIBERS SHALL BE FAIR,
18 SOUND, AND REASONABLE IN RELATION TO THE SERVICES PROVIDED, AND
19 THE PROCEDURES FOR OFFERING AND TERMINATING CONTRACTS SHALL NOT
20 BE UNFAIRLY DISCRIMINATORY.

21 (2) A HEALTH MAINTENANCE ORGANIZATION CONTRACT AND THE
22 CONTRACT'S RATES SHALL NOT DISCRIMINATE ON THE BASIS OF RACE,
23 COLOR, CREED, NATIONAL ORIGIN, RESIDENCE WITHIN THE APPROVED
24 SERVICE AREA OF THE HEALTH MAINTENANCE ORGANIZATION, LAWFUL OCCU-
25 PATION, SEX, HANDICAP, OR MARITAL STATUS, EXCEPT THAT MARITAL
26 STATUS MAY BE USED TO CLASSIFY INDIVIDUALS OR RISKS FOR THE
27 PURPOSE OF INSURING FAMILY UNITS. THE COMMISSIONER MAY APPROVE A

1 RATE DIFFERENTIAL BASED ON SEX, AGE, RESIDENCE, DISABILITY,
2 MARITAL STATUS, OR LAWFUL OCCUPATION, IF THE DIFFERENTIAL IS SUP-
3 PORTED BY SOUND ACTUARIAL PRINCIPLES, A REASONABLE CLASSIFICATION
4 SYSTEM, AND IS RELATED TO THE ACTUAL AND CREDIBLE LOSS STATISTICS
5 OR REASONABLY ANTICIPATED EXPERIENCE FOR NEW COVERAGES.

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

8 SEC. 3521. (1) THE METHODOLOGY USED TO DETERMINE PREPAYMENT
9 RATES BY CATEGORY RATES CHARGED BY THE HEALTH MAINTENANCE ORGANI-
10 ZATION AND ANY CHANGES TO EITHER THE METHODOLOGY OR THE RATES
11 SHALL BE FILED WITH AND APPROVED BY THE COMMISSIONER BEFORE
12 BECOMING EFFECTIVE.

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

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

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

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

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

- 1 (A) NAME AND ADDRESS OF THE ORGANIZATION.
- 2 (B) DEFINITIONS OF TERMS SUBJECT TO INTERPRETATION.
- 3 (C) THE EFFECTIVE DATE AND DURATION OF COVERAGE.
- 4 (D) THE CONDITIONS OF ELIGIBILITY.
- 5 (E) A STATEMENT OF RESPONSIBILITY FOR PAYMENTS.
- 6 (F) A DESCRIPTION OF SPECIFIC BENEFITS AND SERVICES AVAIL-
7 ABLE UNDER THE CONTRACT WITHIN THE SERVICE AREA, WITH RESPECTIVE
8 COPAYMENTS.
- 9 (G) A DESCRIPTION OF EMERGENCY AND OUT-OF-AREA SERVICES.
- 10 (H) A SPECIFIC DESCRIPTION OF ANY LIMITATION, EXCLUSION, AND
11 EXCEPTION, INCLUDING ANY PREEXISTING CONDITION LIMITATION,
12 GROUPED TOGETHER WITH CAPTIONS IN BOLDFACED TYPE.
- 13 (I) COVENANTS WHICH ADDRESS CONFIDENTIALITY, AN ENROLLEE'S
14 RIGHT TO CHOOSE OR CHANGE THE PRIMARY CARE PHYSICIAN OR OTHER
15 PROVIDERS, AVAILABILITY AND ACCESSIBILITY OF SERVICES, AND ANY
16 RIGHTS OF THE ENROLLEE TO INSPECT AND REVIEW HIS OR HER MEDICAL
17 RECORDS.
- 18 (J) COVENANTS OF THE SUBSCRIBER SHALL ADDRESS ALL OF THE
19 FOLLOWING SUBJECTS:
 - 20 (i) TIMELY PAYMENT.
 - 21 (ii) NONASSIGNMENT OF BENEFITS.
 - 22 (iii) TRUTH IN APPLICATION AND STATEMENTS.
 - 23 (iv) NOTIFICATION OF CHANGE IN ADDRESS.
 - 24 (v) THEFT OF MEMBERSHIP IDENTIFICATION.
- 25 (K) A STATEMENT OF RESPONSIBILITIES AND RIGHTS REGARDING THE
26 GRIEVANCE PROCEDURE.

1 (L) A STATEMENT REGARDING SUBROGATION AND COORDINATION OF
2 BENEFITS PROVISIONS, INCLUDING ANY RESPONSIBILITY OF THE ENROLLEE
3 TO COOPERATE.

4 (M) A STATEMENT REGARDING CONVERSION RIGHTS.

5 (N) PROVISIONS FOR ADDING NEW FAMILY MEMBERS OR OTHER
6 ACQUIRED DEPENDENTS, INCLUDING CONVERSION OF INDIVIDUAL CONTRACTS
7 TO FAMILY CONTRACTS AND FAMILY CONTRACTS TO INDIVIDUAL CONTRACTS,
8 AND THE TIME CONSTRAINTS IMPOSED.

9 (O) PROVISIONS FOR GRACE PERIODS FOR LATE PAYMENT.

10 (P) A DESCRIPTION OF ANY SPECIFIC TERMS UNDER WHICH THE
11 HEALTH MAINTENANCE ORGANIZATION OR THE SUBSCRIBER CAN TERMINATE
12 THE CONTRACT.

13 (Q) A STATEMENT OF THE NONASSIGNABILITY OF THE CONTRACT.

14 SEC. 3525. (1) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION
15 (2), IF A HEALTH MAINTENANCE ORGANIZATION DESIRES TO CHANGE A
16 CONTRACT IT OFFERS TO ENROLLEES OR DESIRES TO CHANGE A RATE
17 CHARGED, A COPY OF THE PROPOSED REVISED CONTRACT OR RATE SHALL BE
18 FILED WITH THE COMMISSIONER AND SHALL NOT TAKE EFFECT UNTIL 60
19 DAYS AFTER THE FILING, UNLESS THE COMMISSIONER APPROVES THE
20 CHANGE IN WRITING BEFORE THE EXPIRATION OF 60 DAYS AFTER THE
21 FILING. IF THE COMMISSIONER CONSIDERS THAT THE PROPOSED REVISED
22 CONTRACT OR RATE IS ILLEGAL OR UNREASONABLE IN RELATION TO THE
23 SERVICES PROVIDED, THE COMMISSIONER, NOT MORE THAN 60 DAYS AFTER
24 THE PROPOSED REVISED CONTRACT OR RATE IS FILED, SHALL NOTIFY THE
25 ORGANIZATION IN WRITING, SPECIFYING THE REASONS FOR DISAPPROVAL
26 OR FOR APPROVAL WITH MODIFICATIONS. FOR AN APPROVAL WITH
27 MODIFICATIONS, THE NOTICE SHALL SPECIFY WHAT MODIFICATIONS IN THE

1 FILING ARE REQUIRED FOR APPROVAL, THE REASONS FOR THE
2 MODIFICATIONS, AND THAT THE FILING BECOMES EFFECTIVE AFTER THE
3 MODIFICATIONS ARE MADE AND APPROVED BY THE COMMISSIONER. THE
4 COMMISSIONER SHALL SCHEDULE A HEARING NOT MORE THAN 30 DAYS AFTER
5 RECEIPT OF A WRITTEN REQUEST FROM THE HEALTH MAINTENANCE ORGANI-
6 ZATION, AND THE REVISED CONTRACT OR RATE SHALL NOT TAKE EFFECT
7 UNTIL APPROVED BY THE COMMISSIONER AFTER THE HEARING. WITHIN 30
8 DAYS AFTER THE HEARING, THE COMMISSIONER SHALL NOTIFY THE ORGANI-
9 ZATION IN WRITING OF THE DISPOSITION OF THE PROPOSED REVISED CON-
10 TRACT OR RATE, TOGETHER WITH THE COMMISSIONER'S FINDINGS OF FACT
11 AND CONCLUSIONS.

12 (2) IF THE REVISED CONTRACT OR RATE IS THE RESULT OF COLLEC-
13 TIVE BARGAINING AND AFFECTS ONLY THE MEMBERS OF THE GROUPS
14 ENGAGED IN THE COLLECTIVE BARGAINING, SUBSECTION (1) DOES NOT
15 APPLY BUT THE REVISED CONTRACT OR RATE SHALL BE IMMEDIATELY FILED
16 WITH THE COMMISSIONER.

17 (3) NOT LESS THAN 30 DAYS BEFORE THE EFFECTIVE DATE OF A
18 PROPOSED CHANGE IN A HEALTH MAINTENANCE CONTRACT OR THE RATE
19 CHARGED, THE HEALTH MAINTENANCE ORGANIZATION SHALL ISSUE TO EACH
20 SUBSCRIBER OR GROUP OF SUBSCRIBERS WHO WILL BE AFFECTED BY THE
21 PROPOSED CHANGE A CLEAR WRITTEN STATEMENT STATING THE EXTENT AND
22 NATURE OF THE PROPOSED CHANGE. IF THE COMMISSIONER HAS APPROVED
23 A PROPOSED CHANGE IN A CONTRACT OR RATE IN WRITING BEFORE THE
24 EXPIRATION OF 60 DAYS AFTER THE DATE OF FILING, THE ORGANIZATION
25 IMMEDIATELY SHALL NOTIFY EACH SUBSCRIBER OR GROUP OF SUBSCRIBERS
26 WHO WILL BE AFFECTED BY THE PROPOSED CHANGE.

1 SEC. 3527. (1) UPON OBTAINING A CERTIFICATE OF AUTHORITY, A
2 HEALTH MAINTENANCE ORGANIZATION MAY ENTER INTO HEALTH MAINTENANCE
3 CONTRACTS AND ENGAGE IN OTHER ACTIVITIES CONSISTENT WITH THIS
4 PART AND OTHER APPLICABLE LAWS OF THIS STATE THAT ARE NECESSARY
5 TO PERFORM ITS OBLIGATIONS UNDER ITS CONTRACTS.

6 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL NOT TERMINATE A
7 HEALTH MAINTENANCE CONTRACT OR DENY A RENEWAL OF A CONTRACT
8 BECAUSE OF AGE, SEX, HEALTH STATUS, NATIONAL ORIGIN, OR FREQUENCY
9 OF UTILIZATION OF MEDICALLY INDICATED SERVICES OF AN ENROLLEE OR
10 GROUP OF ENROLLEES.

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

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

18 (A) ESTABLISH WRITTEN POLICIES AND PROCEDURES FOR CREDEN-
19 TIALING VERIFICATION OF ALL HEALTH CARE PROFESSIONALS WITH WHOM
20 THE HEALTH MAINTENANCE ORGANIZATION CONTRACTS AND SHALL APPLY
21 THESE STANDARDS CONSISTENTLY.

22 (B) VERIFY THE CREDENTIALS OF A HEALTH CARE PROFESSIONAL
23 BEFORE ENTERING INTO A CONTRACT WITH THAT HEALTH CARE
24 PROFESSIONAL. THE HEALTH MAINTENANCE ORGANIZATION'S MEDICAL
25 DIRECTOR OR OTHER DESIGNATED HEALTH CARE PROFESSIONAL SHALL HAVE
26 RESPONSIBILITY FOR, AND SHALL PARTICIPATE IN, HEALTH CARE
27 PROFESSIONAL CREDENTIALING VERIFICATION.

1 (C) ESTABLISH A CREDENTIALING VERIFICATION COMMITTEE
2 CONSISTING OF LICENSED PHYSICIANS AND OTHER HEALTH CARE PROFES-
3 SIONALS TO REVIEW CREDENTIALING VERIFICATION INFORMATION AND SUP-
4 PORTING DOCUMENTS AND MAKE DECISIONS REGARDING CREDENTIALING
5 VERIFICATION.

6 (D) MAKE AVAILABLE FOR REVIEW BY THE APPLYING HEALTH CARE
7 PROFESSIONAL UPON WRITTEN REQUEST ALL APPLICATION AND CREDENTIAL-
8 ING VERIFICATION POLICIES AND PROCEDURES.

9 (E) RETAIN ALL RECORDS AND DOCUMENTS RELATING TO A HEALTH
10 CARE PROFESSIONAL'S CREDENTIALING VERIFICATION PROCESS FOR AT
11 LEAST 2 YEARS.

12 (F) KEEP CONFIDENTIAL ALL INFORMATION OBTAINED IN THE CRE-
13 DENTIALING VERIFICATION PROCESS, EXCEPT AS OTHERWISE PROVIDED BY
14 LAW.

15 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL OBTAIN PRIMARY
16 VERIFICATION OF AT LEAST ALL OF THE FOLLOWING INFORMATION ABOUT
17 AN APPLICANT TO BECOME AN AFFILIATED PROVIDER WITH THE HEALTH
18 MAINTENANCE ORGANIZATION:

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

21 (B) CURRENT LEVEL OF PROFESSIONAL LIABILITY COVERAGE, IF
22 APPLICABLE.

23 (C) STATUS OF HOSPITAL PRIVILEGES, IF APPLICABLE.

24 (D) SPECIALTY BOARD CERTIFICATION STATUS, IF APPLICABLE.

25 (E) CURRENT DRUG ENFORCEMENT AGENCY (DEA) REGISTRATION CER-
26 TIFICATE, IF APPLICABLE.

1 (F) GRADUATION FROM MEDICAL SCHOOL.

2 (G) COMPLETION OF POSTGRADUATE TRAINING, IF APPLICABLE.

3 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL OBTAIN, SUBJECT
4 TO EITHER PRIMARY OR SECONDARY VERIFICATION AT THE HEALTH MAINTENANCE ORGANIZATION'S DISCRETION, ALL OF THE FOLLOWING INFORMATION
5 ABOUT AN APPLICANT TO BECOME AN AFFILIATED PROVIDER WITH THE
6 HEALTH MAINTENANCE ORGANIZATION:

8 (A) THE HEALTH CARE PROFESSIONAL'S LICENSE HISTORY IN THIS
9 AND ALL OTHER STATES.

10 (B) THE HEALTH CARE PROFESSIONAL'S MALPRACTICE HISTORY.

11 (C) THE HEALTH CARE PROFESSIONAL'S PRACTICE HISTORY.

12 (4) A HEALTH MAINTENANCE ORGANIZATION SHALL OBTAIN AT LEAST
13 EVERY 3 YEARS PRIMARY VERIFICATION OF ALL OF THE FOLLOWING FOR A
14 PARTICIPATING HEALTH CARE PROFESSIONAL:

15 (A) CURRENT LICENSE TO PRACTICE MEDICINE IN THIS STATE.

16 (B) CURRENT LEVEL OF PROFESSIONAL LIABILITY COVERAGE, IF
17 APPLICABLE.

18 (C) STATUS OF HOSPITAL PRIVILEGES, IF APPLICABLE.

19 (D) CURRENT DEA REGISTRATION CERTIFICATE, IF APPLICABLE.

20 (E) SPECIALTY BOARD CERTIFICATION STATUS, IF APPLICABLE.

21 (5) A HEALTH MAINTENANCE ORGANIZATION SHALL REQUIRE ALL PAR-
22 TICIPATING PROVIDERS TO NOTIFY THE HEALTH MAINTENANCE ORGANIZA-
23 TION OF CHANGES IN THE STATUS OF ANY OF THE ITEMS LISTED IN THIS
24 SECTION AT ANY TIME AND IDENTIFY FOR AFFILIATED PROVIDERS THE
25 INDIVIDUAL TO WHOM THEY SHOULD REPORT CHANGES IN THE STATUS OF AN
26 ITEM LISTED IN THIS SECTION.

1 (6) A HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE A HEALTH
2 CARE PROFESSIONAL WITH THE OPPORTUNITY TO REVIEW AND CORRECT
3 INFORMATION SUBMITTED IN SUPPORT OF THAT HEALTH CARE
4 PROFESSIONAL'S CREDENTIALING VERIFICATION APPLICATION AS
5 FOLLOWS:

6 (A) EACH HEALTH CARE PROFESSIONAL WHO IS SUBJECT TO THE CRE-
7 DENTIALING VERIFICATION PROCESS HAS THE RIGHT TO REVIEW ALL
8 INFORMATION, INCLUDING THE SOURCE OF THAT INFORMATION, OBTAINED
9 BY THE HEALTH MAINTENANCE ORGANIZATION TO SATISFY THE REQUIRE-
10 MENTS OF THIS SECTION DURING THE HEALTH MAINTENANCE
11 ORGANIZATION'S CREDENTIALING PROCESS.

12 (B) A HEALTH MAINTENANCE ORGANIZATION SHALL NOTIFY A HEALTH
13 CARE PROFESSIONAL OF ANY INFORMATION OBTAINED DURING THE HEALTH
14 MAINTENANCE ORGANIZATION'S CREDENTIALING VERIFICATION PROCESS
15 THAT DOES NOT MEET THE HEALTH MAINTENANCE ORGANIZATION'S CREDEN-
16 TIALING VERIFICATION STANDARDS OR THAT VARIES SUBSTANTIALLY FROM
17 THE INFORMATION PROVIDED TO THE HEALTH MAINTENANCE ORGANIZATION
18 BY THE HEALTH CARE PROFESSIONAL, EXCEPT THAT THE HEALTH MAINTE-
19 NANCE ORGANIZATION IS NOT REQUIRED TO REVEAL THE SOURCE OF INFOR-
20 MATION IF THE INFORMATION IS NOT OBTAINED TO MEET THE REQUIRE-
21 MENTS OF THIS SECTION OR IF DISCLOSURE IS PROHIBITED BY LAW.

22 (C) A HEALTH CARE PROFESSIONAL HAS THE RIGHT TO CORRECT ANY
23 ERRONEOUS INFORMATION. A HEALTH MAINTENANCE ORGANIZATION SHALL
24 HAVE A FORMAL PROCESS BY WHICH A HEALTH CARE PROFESSIONAL MAY
25 SUBMIT SUPPLEMENTAL OR CORRECTED INFORMATION TO THE HEALTH MAIN-
26 TENANCE ORGANIZATION'S CREDENTIALING VERIFICATION COMMITTEE AND
27 REQUEST A RECONSIDERATION OF THE HEALTH CARE PROFESSIONAL'S

1 CREDENTIALING VERIFICATION APPLICATION IF THE HEALTH CARE
2 PROFESSIONAL FEELS THAT THE HEALTH CARRIER'S CREDENTIALING VERI-
3 FICATION COMMITTEE HAS RECEIVED INFORMATION THAT IS INCORRECT OR
4 MISLEADING. SUPPLEMENTAL INFORMATION IS SUBJECT TO CONFIRMATION
5 BY THE HEALTH MAINTENANCE ORGANIZATION.

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

12 (8) NOTHING IN THIS ACT SHALL BE CONSTRUED TO REQUIRE A
13 HEALTH MAINTENANCE ORGANIZATION TO SELECT A PROVIDER AS AN AFFIL-
14 IATED PROVIDER SOLELY BECAUSE THE PROVIDER MEETS THE HEALTH MAIN-
15 TENANCE ORGANIZATION'S CREDENTIALING VERIFICATION STANDARDS, OR
16 TO PREVENT A HEALTH MAINTENANCE ORGANIZATION FROM UTILIZING SEPA-
17 RATE OR ADDITIONAL CRITERIA IN SELECTING THE HEALTH CARE PROFES-
18 SIONALS WITH WHOM IT CONTRACTS.

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

1 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL ENTER INTO
2 CONTRACTS WITH PROVIDERS THROUGH WHICH HEALTH CARE SERVICES ARE
3 USUALLY PROVIDED TO ENROLLEES UNDER THE HEALTH MAINTENANCE ORGAN-
4 IZATION PLAN.

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

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

12 (A) THE PROVIDER MEETS APPLICABLE LICENSURE OR CERTIFICATION
13 REQUIREMENTS.

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

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

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

1 MAINTAIN A HOSPITAL RESERVE FUND EQUAL TO 3 MONTHS' PROJECTED
2 CLAIMS FROM SUCH HOSPITALS.

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

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

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

1 PARTICIPATING PROVIDERS, HOURS OF OPERATION, AND THE VOLUME OF
2 TECHNOLOGICAL AND SPECIALTY SERVICES AVAILABLE TO SERVE THE NEEDS
3 OF ENROLLEES REQUIRING TECHNOLOGICALLY ADVANCED OR SPECIALTY
4 CARE.

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

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

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

22 (2) A HEALTH MAINTENANCE ORGANIZATION MAY ENTER INTO A CON-
23 TRACT WITH 1 OR MORE HEALTH CARE PROVIDERS TO CONTROL HEALTH CARE
24 COSTS, ASSURE APPROPRIATE UTILIZATION OF HEALTH MAINTENANCE SERV-
25 ICES, AND MAINTAIN QUALITY OF HEALTH CARE. THE HEALTH MAINTENANCE
26 ORGANIZATION MAY LIMIT THE NUMBER OF CONTRACTS ENTERED INTO
27 UNDER THIS SECTION IF THE NUMBER OF CONTRACTS IS SUFFICIENT TO

1 ASSURE REASONABLE LEVELS OF ACCESS TO HEALTH MAINTENANCE SERVICES
2 FOR RECIPIENTS OF THOSE SERVICES. THE NUMBER OF CONTRACTS AUTHO-
3 RIZED BY THIS SECTION THAT ARE NECESSARY TO ASSURE REASONABLE
4 LEVELS OF ACCESS TO HEALTH MAINTENANCE SERVICES FOR RECIPIENTS
5 SHALL BE DETERMINED BY THE HEALTH MAINTENANCE ORGANIZATION AS
6 APPROVED BY THE COMMISSIONER UNDER THIS CHAPTER. HOWEVER, THE
7 HEALTH MAINTENANCE ORGANIZATION SHALL OFFER A CONTRACT, COM-
8 PARABLE TO THOSE CONTRACTS ENTERED INTO WITH OTHER AFFILIATED
9 PROVIDERS, TO AT LEAST 1 HEALTH CARE PROVIDER THAT PROVIDES THE
10 APPLICABLE HEALTH MAINTENANCE SERVICES AND IS LOCATED WITHIN A
11 REASONABLE DISTANCE FROM THE RECIPIENTS OF THOSE HEALTH MAINTE-
12 NANCE SERVICES, IF A HEALTH CARE PROVIDER THAT PROVIDES THE
13 APPLICABLE HEALTH MAINTENANCE SERVICES IS LOCATED WITHIN THAT
14 REASONABLE DISTANCE.

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

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

25 (A) STANDARDS FOR MAINTAINING QUALITY HEALTH CARE.

26 (B) STANDARDS FOR CONTROLLING HEALTH CARE COSTS.

1 (C) STANDARDS FOR ASSURING APPROPRIATE UTILIZATION OF HEALTH
2 CARE SERVICES.

3 (D) STANDARDS FOR ASSURING REASONABLE LEVELS OF ACCESS TO
4 HEALTH CARE SERVICES.

5 (E) OTHER STANDARDS CONSIDERED APPROPRIATE BY THE HEALTH
6 MAINTENANCE ORGANIZATION.

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

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

21 (7) A HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE FOR AN
22 INITIAL 60-DAY PROVIDER APPLICATION PERIOD DURING WHICH PROVIDERS
23 MAY APPLY TO THE HEALTH MAINTENANCE ORGANIZATION TO BECOME AFFIL-
24 IATED PROVIDERS. A HEALTH MAINTENANCE ORGANIZATION THAT HAS
25 ENTERED INTO A CONTRACT WITH AN AFFILIATED PROVIDER SHALL PRO-
26 VIDE, AT LEAST ONCE EVERY 4 YEARS, FOR A 60-DAY PROVIDER
27 APPLICATION PERIOD DURING WHICH A PROVIDER MAY APPLY TO THE

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

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

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

26 SEC. 3533. (1) A HEALTH MAINTENANCE ORGANIZATION MAY OFFER
27 PRUDENT PURCHASER CONTRACTS TO GROUPS OR INDIVIDUALS AND IN

1 CONJUNCTION WITH THOSE CONTRACTS A HEALTH MAINTENANCE
2 ORGANIZATION MAY PAY OR MAY REIMBURSE ENROLLEES, OR MAY CONTRACT
3 WITH ANOTHER ENTITY TO PAY OR REIMBURSE ENROLLEES, FOR UNAUTHO-
4 RIZED SERVICES OR FOR SERVICES BY NONAFFILIATED PROVIDERS IN
5 ACCORDANCE WITH THE TERMS OF THE CONTRACT AND SUBJECT TO COPAY-
6 MENTS, DEDUCTIBLES, OR OTHER FINANCIAL PENALTIES DESIGNED TO
7 ENCOURAGE ENROLLEES TO OBTAIN SERVICES FROM THE ORGANIZATION'S
8 PROVIDERS.

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

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

24 (4) A HEALTH MAINTENANCE ORGANIZATION SHALL MAINTAIN FINAN-
25 CIAL RECORDS FOR ITS PRUDENT PURCHASER CONTRACTS AND ACTIVITIES
26 IN A FORM SEPARATE OR SEPARABLE FROM THE FINANCIAL RECORDS OF
27 OTHER OPERATIONS AND ACTIVITIES CARRIED ON BY THE ORGANIZATION.

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

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

26 (A) IT HAS ENROLLED, OR WILL BE COMPELLED TO ENROLL, A
27 DISPROPORTIONATE NUMBER OF INDIVIDUALS WHO ARE LIKELY TO UTILIZE

1 ITS SERVICES MORE OFTEN THAN AN ACTUARIALLY DETERMINED AVERAGE AS
2 DETERMINED UNDER RULES PROMULGATED BY THE COMMISSIONER, AND
3 ENROLLMENT DURING AN OPEN ENROLLMENT PERIOD OF AN ADDITIONAL
4 NUMBER OF THOSE INDIVIDUALS WILL JEOPARDIZE ITS ECONOMIC
5 VIABILITY.

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

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

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

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

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

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

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

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

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

16 SEC. 3541. A HEALTH MAINTENANCE ORGANIZATION SHALL NOT PROHIBIT
17 OR DISCOURAGE A HEALTH PROFESSIONAL FROM ADVOCATING ON
18 BEHALF OF AN ENROLLEE FOR APPROPRIATE MEDICAL TREATMENT OPTIONS
19 PURSUANT TO THE GRIEVANCE PROCEDURE IN SECTION 2213 OR THE HEALTH
20 CARRIER EXTERNAL REVIEW ACT OR FROM DISCUSSING WITH AN ENROLLEE
21 OR PROVIDER ANY OF THE FOLLOWING:

22 (A) HEALTH CARE TREATMENTS AND SERVICES.

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

24 (C) THE FINANCIAL RELATIONSHIPS BETWEEN THE HEALTH MAINTENANCE
25 ORGANIZATION AND THE HEALTH PROFESSIONAL INCLUDING ALL OF
26 THE FOLLOWING AS APPLICABLE:

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

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

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

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

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

19 (B) THE THIRD PARTY ADMINISTRATOR HAS A CERTIFICATE OF
20 AUTHORITY ISSUED PURSUANT TO THE THIRD PARTY ADMINISTRATOR ACT,
21 1984 PA 218, MCL 550.901 TO 550.962.

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

25 (D) THE INVESTMENT IN THE THIRD PARTY ADMINISTRATOR BY THE
26 HEALTH MAINTENANCE ORGANIZATION DOES NOT ENDANGER THE CONTINUED
27 OPERATION OF THE HEALTH MAINTENANCE ORGANIZATION.

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

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

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

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

22 SEC. 3547. (1) THE COMMISSIONER AT ANY TIME MAY VISIT OR
23 EXAMINE THE HEALTH CARE SERVICE OPERATIONS OF A HEALTH MAINTE-
24 NANCE ORGANIZATION AND CONSULT WITH ENROLLEES TO THE EXTENT NEC-
25 ESSARY TO CARRY OUT THE INTENT OF THIS CHAPTER.

26 (2) IN ADDITION TO THE AUTHORITY GRANTED UNDER CHAPTER 2,
27 THE COMMISSIONER:

1 (A) SHALL HAVE ACCESS TO ALL INFORMATION OF THE HEALTH
2 MAINTENANCE ORGANIZATION RELATING TO THE DELIVERY OF HEALTH SERV-
3 ICES, INCLUDING, BUT NOT LIMITED TO BOOKS, PAPERS, COMPUTER DATA-
4 BASES, AND DOCUMENTS, IN A MANNER THAT PRESERVES THE CONFIDEN-
5 TIALITY OF THE HEALTH RECORDS OF INDIVIDUAL ENROLLEES.

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

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

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

22 (3) A HEALTH MAINTENANCE ORGANIZATION SHALL HOLD AND MAIN-
23 TAIN LEGAL TITLE TO ALL ASSETS, INCLUDING CASH AND INVESTMENTS.
24 HEALTH MAINTENANCE ORGANIZATION FUNDS AND ASSETS SHALL NOT BE
25 COMMINGLED WITH AFFILIATES OR OTHER ENTITIES IN POOLING OR CASH
26 MANAGEMENT TYPE ARRANGEMENTS. ALL HEALTH MAINTENANCE

1 ORGANIZATION ASSETS SHALL BE HELD SEPARATE FROM ALL OTHER
2 ACTIVITIES OF OTHER MEMBERS IN A HOLDING COMPANY SYSTEM.

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

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

23 (2) A HEALTH MAINTENANCE ORGANIZATION LICENSED UNDER FORMER
24 PART 210 OF THE PUBLIC HEALTH CODE, 1978 PA 368, ON THE EFFECTIVE
25 DATE OF THIS CHAPTER THAT AUTOMATICALLY RECEIVED A CERTIFICATE OF
26 AUTHORITY UNDER SECTION 3505(1) SHALL POSSESS AND MAINTAIN
27 UNIMPAIRED NET WORTH AS REQUIRED UNDER FORMER SECTION 21034 OF

1 THE PUBLIC HEALTH CODE, 1978 PA 368, UNTIL THE EARLIER OF THE
2 FOLLOWING:

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

7 (B) DECEMBER 31, 2003.

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

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

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

20 (ii) FIVE PERCENT OF THE HEALTH MAINTENANCE ORGANIZATION'S
21 SUBSCRIPTION REVENUE.

22 (iii) THREE MONTHS' UNCOVERED EXPENDITURES.

23 (B) FOR A HEALTH MAINTENANCE ORGANIZATION THAT DOES NOT CON-
24 TRACT OR EMPLOY PROVIDERS IN NUMBERS SUFFICIENT TO PROVIDE 90% OF
25 THE HEALTH MAINTENANCE ORGANIZATION'S BENEFIT PAYOUT, MINIMUM NET
26 WORTH IS THE GREATEST OF THE FOLLOWING:

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

2 (ii) TEN PERCENT OF THE HEALTH MAINTENANCE ORGANIZATION'S
3 SUBSCRIPTION REVENUE.

4 (iii) THREE MONTHS' UNCOVERED EXPENDITURES.

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

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

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

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

24 (B) DECEMBER 31, 2001.

25 (3) A HEALTH MAINTENANCE ORGANIZATION APPLYING FOR A CERTIF-
26 ICATE OF AUTHORITY ON OR AFTER THE EFFECTIVE DATE OF THIS CHAPTER
27 AND A HEALTH MAINTENANCE ORGANIZATION WISHING TO MAINTAIN A

1 CERTIFICATE OF AUTHORITY IN THIS STATE AFTER DECEMBER 31, 2001
2 SHALL POSSESS AND MAINTAIN A DEPOSIT IN AN AMOUNT DETERMINED ADE-
3 QUATE BY THE COMMISSIONER TO CONTINUE TO COMPLY WITH SECTION 403
4 BUT NOT LESS THAN \$100,000.00 PLUS 5% OF ANNUAL SUBSCRIPTION REV-
5 ENUE UP TO A \$1,000,000.00 MAXIMUM DEPOSIT.

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

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

15 (A) DEMONSTRATE COMPLIANCE WITH ALL HEALTH MAINTENANCE
16 ORGANIZATION FINANCIAL REQUIREMENTS PROVIDED FOR IN THIS
17 CHAPTER.

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

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

25 SEC. 3557. A HEALTH MAINTENANCE ORGANIZATION SHALL FILE
26 NOTICE WITH THE COMMISSIONER OF ANY SUBSTANTIVE CHANGES IN
27 OPERATIONS NO LATER THAN 30 DAYS AFTER THE SUBSTANTIVE CHANGE IN

1 OPERATIONS. A SUBSTANTIVE CHANGE IN OPERATIONS INCLUDES, BUT IS
2 NOT LIMITED TO, ANY OF THE FOLLOWING:

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

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

9 (C) A CHANGE IN THE ORGANIZATION'S ARTICLES OF INCORPORATION
10 OR BYLAWS. A COPY OF THE REVISED ARTICLES OF INCORPORATION OR
11 BYLAWS SHALL BE INCLUDED WITH THE NOTICE.

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

14 (E) ANY OTHER SIGNIFICANT CHANGE IN OPERATIONS.

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

21 (2) A REINSURANCE CONTRACT OR PLAN UNDER SUBSECTION (1)
22 SHALL BE FILED FOR APPROVAL WITH THE COMMISSIONER NOT LATER THAN
23 30 DAYS AFTER THE FINALIZATION OF THE CONTRACT OR PLAN. A REIN-
24 SURANCE CONTRACT OR PLAN SHALL CLEARLY STATE ALL SERVICES TO BE
25 RECEIVED BY THE HEALTH MAINTENANCE ORGANIZATION. A REINSURANCE
26 CONTRACT OR PLAN SHALL BE CONSIDERED APPROVED 30 DAYS AFTER IT IS

1 FILED WITH THE COMMISSIONER UNLESS DISAPPROVED IN WRITING BY THE
2 COMMISSIONER BEFORE THE EXPIRATION OF THOSE 30 DAYS.

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

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

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

22 (B) A REINSURANCE CONTRACT ISSUED BY AN AUTHORIZED OR ELIGI-
23 BLE INSURER TO COVER THE EXPENSES TO BE PAID FOR CONTINUED BENE-
24 FITS AFTER AN INSOLVENCY.

25 (C) A CONTRACT BETWEEN THE HEALTH MAINTENANCE ORGANIZATION
26 AND ITS AFFILIATED PROVIDERS THAT PROVIDES FOR THE CONTINUATION

1 OF PROVIDER SERVICES IN THE EVENT OF THE HEALTH MAINTENANCE
2 ORGANIZATION'S INSOLVENCY.

3 (D) AN IRREVOCABLE LETTER OF CREDIT.

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

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

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

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

12 (3) THE COMMISSIONER SHALL ALLOCATE EQUITABLY THE INSOLVENT
13 HEALTH MAINTENANCE ORGANIZATION'S NONGROUP ENROLLEES WHO ARE
14 UNABLE TO OBTAIN OTHER COVERAGE AMONG ALL HEALTH MAINTENANCE
15 ORGANIZATIONS THAT OPERATE WITHIN A PORTION OF THE INSOLVENT
16 HEALTH MAINTENANCE ORGANIZATION'S SERVICE AREA, TAKING INTO CON-
17 sideration THE HEALTH CARE DELIVERY RESOURCES OF EACH HEALTH
18 MAINTENANCE ORGANIZATION. EACH HEALTH MAINTENANCE ORGANIZATION
19 TO WHICH NONGROUP ENROLLEES ARE ALLOCATED SHALL OFFER THE NON-
20 GROUP ENROLLEES THE HEALTH MAINTENANCE ORGANIZATION'S EXISTING
21 COVERAGE WITHOUT A PREEXISTING CONDITION LIMITATION FOR INDIVID-
22 UAL OR CONVERSION COVERAGE AS DETERMINED BY THE ENROLLEE'S TYPE
23 OF COVERAGE IN THE INSOLVENT HEALTH MAINTENANCE ORGANIZATION AT
24 RATES DETERMINED IN ACCORDANCE WITH THE SUCCESSOR HEALTH MAINTENANCE
25 ORGANIZATION'S EXISTING RATING METHODOLOGY. SUCCESSOR
26 HEALTH MAINTENANCE ORGANIZATIONS THAT DO NOT OFFER DIRECT

1 NONGROUP ENROLLMENT MAY AGGREGATE ALL OF THE ALLOCATED NONGROUP
2 ENROLLEES INTO 1 GROUP FOR RATING AND COVERAGE PURPOSES.

3 SEC. 3565. (1) A NONGROUP SUBSCRIBER, IN ADDITION TO OTHER
4 RIGHTS AVAILABLE TO REVOKE AN OFFER, MAY CANCEL A HEALTH MAINTENANCE
5 CONTRACT WITHIN 72 HOURS AFTER SIGNING. ANY DEPOSIT OR
6 PREPAYMENT MADE SHALL BE REFUNDED WITHIN 30 DAYS OF RECEIPT OF
7 THE NOTICE OF CANCELLATION. A NONGROUP SUBSCRIBER SHALL BE
8 RESPONSIBLE FOR PAYMENT OF REASONABLE FEES FOR ANY SERVICES
9 RECEIVED DURING THE 72 HOURS. FEES MAY BE DEDUCTED FROM THE
10 DEPOSIT OR PREPAYMENT BEFORE THE REFUND IS MADE.

11 (2) CANCELLATION SHALL OCCUR WHEN WRITTEN NOTICE OF CANCELLATION
12 IS MAILED OR HAND-DELIVERED TO THE ORGANIZATION OR ITS
13 AGENT OR REPRESENTATIVE.

14 (3) NOTICE OF CANCELLATION SHALL BE SUFFICIENT IF IT INDICATES
15 THE INTENTION OF THE PERSON NOT TO BE BOUND BY THE CONTRACT
16 OR APPLICATION.

17 (4) THE RIGHT OF CANCELLATION SHALL APPEAR IN BOLDFACED TYPE
18 ON THE SAME PAGE THE INDIVIDUAL SUBSCRIBER SIGNS TO BIND THE
19 CONTRACT.

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

23 (2) A HEALTH MAINTENANCE CONTRACT FOR NONGROUP SUBSCRIBERS
24 SHALL SPECIFY AN ENROLLEE'S RIGHTS AND OPTIONS IN THE CASE OF A
25 PROPOSED AMENDMENT OR CHANGE IN THE CONTRACT OR THE RATE
26 CHARGED.

1 (3) CONTINUED PREPAYMENT BY THE SUBSCRIBER DURING THE PERIOD
2 OF APPEAL, AND WHILE AN APPEAL IS IN PROGRESS, DOES NOT
3 CONSTITUTE ACCEPTANCE OF THE PROPOSED AMENDMENT OR RATE CHANGE.

4 SEC. 3569. (1) EXCEPT AS PROVIDED IN SECTION 3515(2), A
5 HEALTH MAINTENANCE ORGANIZATION SHALL ASSUME FULL FINANCIAL RISK
6 ON A PROSPECTIVE BASIS FOR THE PROVISION OF HEALTH MAINTENANCE
7 SERVICES. HOWEVER, THE ORGANIZATION MAY DO ANY OF THE
8 FOLLOWING:

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

11 (B) OBTAIN INSURANCE.

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

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

18 (A) THE HEALTH MAINTENANCE ORGANIZATION TO PAY THE AFFILI-
19 ATED PROVIDER, INCLUDING A SUBCONTRACTED PROVIDER, DIRECTLY OR
20 THROUGH A LICENSED THIRD PARTY ADMINISTRATOR FOR HEALTH MAINTENANCE
21 SERVICES PROVIDED TO ITS ENROLLEES.

22 (B) THE HEALTH MAINTENANCE ORGANIZATION TO KEEP ALL POOLED
23 FUNDS AND WITHHOLD AMOUNTS AND ACCOUNT FOR THEM ON ITS FINANCIAL
24 BOOKS AND RECORDS AND RECONCILE THEM AT YEAR END IN ACCORDANCE
25 WITH THE WRITTEN AGREEMENT BETWEEN THE AFFILIATED PROVIDER AND
26 THE HEALTH MAINTENANCE ORGANIZATION.

1 (3) AS USED IN THIS SECTION, "REQUIRING AN AFFILIATED
2 PROVIDER TO ASSUME FINANCIAL RISK" MEANS A TRANSACTION WHEREBY A
3 PORTION OF THE CHANCE OF LOSS, INCLUDING EXPENSES INCURRED,
4 RELATED TO THE DELIVERY OF HEALTH MAINTENANCE SERVICES IS SHARED
5 WITH AN AFFILIATED PROVIDER IN RETURN FOR A CONSIDERATION. THESE
6 TRANSACTIONS INCLUDE, BUT ARE NOT LIMITED TO, FULL OR PARTIAL
7 CAPITATION AGREEMENTS, WITHHOLDS, RISK CORRIDORS, AND INDEMNITY
8 AGREEMENTS.

9 SEC. 3571. A HEALTH MAINTENANCE ORGANIZATION IS NOT PRE-
10 CLUDED FROM MEETING THE REQUIREMENTS OF, RECEIVING MONEYS FROM,
11 AND ENROLLING BENEFICIARIES OR RECIPIENTS OF, STATE AND FEDERAL
12 HEALTH PROGRAMS.

13 SEC. 3573. A PERSON PROPOSING TO OPERATE A SYSTEM OF HEALTH
14 CARE DELIVERY AND FINANCING THAT IS TO BE OFFERED TO INDIVIDUALS,
15 WHETHER OR NOT AS MEMBERS OF GROUPS, IN EXCHANGE FOR A FIXED PAY-
16 MENT AND ORGANIZED SO THAT PROVIDERS AND THE ORGANIZATION ARE IN
17 SOME PART AT RISK FOR THE COST OF SERVICES IN A MANNER SIMILAR TO
18 A HEALTH MAINTENANCE ORGANIZATION, BUT FAILS TO MEET THE REQUIRE-
19 MENTS SET FORTH IN THIS CHAPTER, MAY OPERATE SUCH A SYSTEM IF THE
20 COMMISSIONER FINDS THAT THE PROPOSED OPERATION WILL BENEFIT PER-
21 SONS WHO WILL BE SERVED BY IT. THE OPERATION SHALL BE AUTHORIZED
22 AND REGULATED IN THE SAME MANNER AS A HEALTH MAINTENANCE ORGANI-
23 ZATION UNDER THIS CHAPTER INCLUDING THE FILING OF PERIODIC
24 REPORTS, EXCEPT TO THE EXTENT THAT THE COMMISSIONER FINDS THAT
25 THE REGULATION IS INAPPROPRIATE TO THE SYSTEM OF HEALTH CARE
26 DELIVERY AND FINANCING. A PERSON OPERATING A SYSTEM OF HEALTH
27 CARE DELIVERY AND FINANCING UNDER THIS SECTION SHALL NOT

1 ADVERTISE OR SOLICIT OR IN ANY WAY IDENTIFY ITSELF IN A MANNER
 2 IMPLYING TO THE PUBLIC THAT IT IS A HEALTH MAINTENANCE ORGANIZA-
 3 TION AUTHORIZED UNDER THIS CHAPTER.

4 Enacting section 1. Part 210 of the public health code,
 5 1978 PA 368, MCL 333.21001 to 333.21098, is repealed.