House
Legislative
Analysis
Section

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HMO: REGULATE UNDER INSURANCE CODE

House Bill 5574
Sponsor: Rep. Sandra Caul

House Bill 5575
Sponsor: Rep. Gerald Van Woerkom

Committee: Health Policy
Complete to 5-2-00

A SUMMARY OF HOUSE BILLS 5574 AND 5575 AS INTRODUCED 4-12-00

Currently, regulation of health maintenance organizations (HMOs) is overseen by the Department of Community Health and regulated under Part 210 of the Public Health Code. House Bill 5575 would amend the Insurance Code to repeal Part 210 and transfer the regulation of HMOs to the code. House Bill 5574 would amend the Public Health Code to remove references to HMOs that are no longer appropriate in light of the transfer. Specifically, the bills would do the following:

House Bill 5574 would amend the Public Health Code (MCL 333.20106 et al.) to make technical changes regarding HMOs in light of the transfer of the regulatory framework pertaining to HMOs from the Public Health Code to the Insurance Code.

House Bill 5575 would amend the Insurance Code (MCL 500.102 et al.) to, among many things, add Chapter 35, entitled "Health Maintenance Organizations". Part 210 of the Public Health Code (MCL 333.21001 to 333.21098), which currently regulates HMOs, would be repealed. Under the bill, all of the provisions of the Insurance Code that apply to a domestic insurer authorized to issue an expense-incurred hospital, medical, or surgical policy or certificate, including, but not limited to, Section 223 (application for initial or renewal certificate of authority, fee, and deposit), Chapter 34 (disability insurance policies) and Chapter 36 (group and blanket disability) would apply to an HMO unless specifically excluded or otherwise provided for in the bill. However, Chapter 77 (Michigan Life and Health Insurance Guaranty Association Act) and Chapter 79 (Property and Casualty Guaranty Association Act) would not apply to HMOs, nor would several sections pertaining to capital, surplus, or assets; loans and investments; corporate powers; and authority for domestic, alien, and foreign insurers to transact insurance in the state. Oversight would be provided by the commissioner of the Office of Financial and Insurance Services (OFIS). Some of the more significant changes are as follows:

• An HMO would be required to receive a certificate of authority (instead of a license) before issuing health maintenance contracts. A license issued under Part 210 of the Public Health Code would automatically become a certificate of authority on the bill's effective date.

• The bill would change the process by which an HMO's net worth is determined, and would increase the net worth and working capitol requirements. HMOs licensed on the bill's effective date, and which have unimpaired net worth as currently required, would have to come into compliance with the new levels no later than December 31, 2003.

• HMOs applying for a certificate of authority or wishing to maintain a certificate on or after the bill's effective date would have to maintain a deposit in an amount determined adequate by the commissioner, but not less than $100,000 plus five percent of the annual subscription revenue up to a $1 million maximum deposit.

• An HMO would have to hold assets in its own name and not commingle funds and assets with affiliates or other entities.

• The bill would incorporate NAIC model legislation pertaining to insolvency. HMOs would have to have a plan in place to handle insolvency that would allow for the continuation of benefits for the duration of the contract period. The bill would prescribe criteria for satisfying solvency requirements.

• The bill would incorporate numerous provisions currently contained in departmental rules and would also incorporate provisions contained in model legislation proposed by the National Association of Insurance Commissions (NAIC). For example, the bill would incorporate credentialing criteria for health professionals who contract with HMOs that are part of the NAIC credentialing model act.

• The bill would make changes to the grievance procedure for insurers and HMOs. Beginning October 1, 2000, a notification of an adverse determination would have to include a written notice in plain English that the insured or enrollee could request a review by an independent review organization under the Patient's Right to Independent Review Act (House Bill 5576). An insured or enrollee could authorize, in writing, any person (including a physician) to act on his or her behalf during the grievance proceeding. The time frame in which a final determination is to be issued would be reduced from 90 days after the insured or enrollee submitted a formal grievance to 45 days. Currently, summary data on the number and types of complaints and grievances filed is collected. Beginning April 15, 2001, the data for the previous year would have to be filed annually with the commissioner of the Office of Financial and Insurance Services on forms provided by the commissioner.

• The regulatory fee for HMOs would be calculated using the same formula as for other insurers. Other fees paid by insurers that would be applicable to HMOs include a $25 filing fee and a $5 agent's appointment fee.

• Each HMO would have to develop and maintain a quality assessment program to assess the quality of health care provided to enrollees and a quality improvement program to design, measure, assess, and improve the processes and outcomes of health care as identified in the program.

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