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SFA BILL ANALYSIS

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Senate Bill 1209 (as enrolled) **PUBLIC ACT 252 of 2000**
Sponsor: Senator Bev Hammerstrom
Senate Committee: Health Policy
House Committee: Health Policy

Date Completed: 8-17-00

CONTENT

The bill added Chapter 35 (Health Maintenance Organizations) to the Insurance Code to provide for oversight of health maintenance organizations (HMOs) by the Commissioner of the Office of Financial and Insurance Services; and repealed Part 210 of the Public Health Code, which provided for HMO oversight by the Insurance Bureau and the Department of Community Health (DCH). The bill also does the following:

- **Extends to HMOs the filing fee and agent fee that apply to insurers.**
- **Revises the internal grievance procedure that insurers must establish, and extends that procedure to HMOs.**
- **Requires both insurers and HMOs to comply with external review provisions under the Patient's Right to Independent Review Act.**
- **Provides that, with certain exceptions, all of the provisions of the Insurance Code that apply to domestic health insurers apply to HMOs.**
- **Requires HMOs to receive a certificate of authority from the Commissioner.**
- **Requires HMOs to develop and maintain quality assessment and improvement programs.**
- **Requires that HMO contracts be approved by the Commissioner.**
- **Requires HMOs to verify the credentials of health care professionals.**
- **Sets forth HMOs' authority to contract with or employ health professionals, and HMOs' responsibility to maintain contracts with affiliated providers.**
- **Prohibits HMOs from inducing health professionals to deny medically necessary and appropriate services.**
- **Allows HMOs to acquire obligations from other managed care facilities.**
- **Specifies financial requirements for HMOs, including unimpaired net worth levels and minimum deposits.**
- **Requires certain actions to be taken if an HMO becomes insolvent.**
- **Requires HMO contracts to specify conditions under which an HMO may cancel enrollees' coverage.**

The following overview describes provisions in Chapter 35 that were not in Part 210, or that are different from previous provisions.

Application of Insurance Code to HMOs

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 also apply to an HMO under Chapter 35 unless specifically excluded, or otherwise specifically provided for in Chapter 35. Applicable provisions include, but are not limited to, Section 223 (which requires insurers to pay a $500 fee with an application for an original or renewed certificate of authority), and Chapters 34 and 36 (which govern disability insurance policies and group and blanket disability insurance, respectively).

The following do not apply to an HMO:

- Sections 408, 410, and 411 (which specify requirements for insurers' paid-in capital or surplus or assets, unimpaired capital and surplus, and deposits).
- Section 901 (which governs insurers' loans and investments).
- Section 5208 (which describes insurers' corporate powers).
- Chapter 77 (which contains the Michigan Life and Health Guaranty Association Act).
- Chapter 79 (which contains the Property and Casualty Guaranty Association Act).

Certificate of Authority/Fees

The bill requires the Commissioner of the Office of

Financial and Insurance Services, in the Department of Consumer and Industry Services (DCIS), to establish a system of authorizing and regulating HMOs in this State. (Previously, Part 210 required the DCH, in conjunction with the Insurance Bureau in the DCIS, to establish a system of licensing and regulating HMOs.)

The bill requires an HMO to receive a certificate of authority under Chapter 35 before issuing health maintenance contracts. An HMO license issued under Part 210 automatically became a certificate of authority on the bill's effective date (June 29, 2000).

A certificate of authority issued under Chapter 35 is limited to the service area described in the application for the certificate. (The bill defines "service area" as a defined geographical area in which health maintenance services are generally available and readily accessible to enrollees and where HMOs may market their contracts.) An HMO seeking to change the approved service area must submit an application to the Commissioner and may not change the service area until approval is received.

The bill deleted provisions that governed the calculation of an HMO's regulatory fee. The bill extends to HMOs the $25 filing fee for original authorization to transact business, and the $5 agent's appointment fee that apply to insurers.

The bill deleted a $2 fee for certification of records.

HMO Contract/Basic Services

The bill requires all HMO contracts to include, at a minimum, basic health services. (The former and new definitions of "basic health services" include physician services, including consultant and referral services by a physician, but not psychiatric services; ambulatory services; inpatient hospital services, other than those for treatment of mental illness; emergency health services; outpatient mental health services, not fewer than 20 visits per year; and intermediate and outpatient care for substance abuse.)

The bill recodified the former definition of "health maintenance contract". The new definition specifies, however, that the term includes, at a minimum, basic health maintenance services, while the former definition referred to "primary" health maintenance services. (Under the Public Health Code, "primary health maintenance services" means physician services, including consultant and referral services but not psychiatric services; ambulatory services; inpatient hospital services, other than for the treatment of mental illness; emergency health services; diagnostic laboratory and diagnostic and therapeutic radiological services; and preventive health services.)

The bill's definition of "health maintenance contract" also specifies that the term includes a prudent purchaser contract.

Under the bill, a health maintenance contract must be filed with and approved by the Commissioner. A contract must include any approved riders, amendments, and the enrollment application. In addition to the provisions of the Insurance Code that apply to a health policy, a health maintenance contract must include the following:

-- The organization's name and address.
-- Definitions of terms subject to interpretation.
-- The effective date and duration of the contract.
-- The conditions of eligibility.
-- A statement of responsibility for payments.
-- A description of specified benefits and services available under the contract within the service area, with respective copayments.
-- A description of emergency and out-of-area services.
-- A specific description of any limitation, exclusion, and exception, including any preexisting condition limitation.
-- Covenants addressing confidentiality, an enrollee's right to choose or change the primary care physician or other provider, availability and accessibility of services, and any rights of the enrollee to inspect and review his or her medical records.
-- Covenants of the subscriber addressing timely payment, nonassignment of benefits, truth in application and statements, notification of change of address, and theft of membership identification.
-- A statement of responsibilities and rights regarding the grievance procedure.
-- A statement regarding subrogation and coordination of benefits provisions.
-- A statement regarding conversion rights.
-- Provisions for adding new family members or other acquired dependents, and the time constraints imposed.
-- Provisions for grace periods for late payment.
-- A description of any specific terms under which the HMO or the subscriber may terminate the contract.
-- A statement of the nonassignability of the contract.

Quality Assessment and Improvement Programs

The bill requires an HMO to develop and maintain a quality assessment program to assess the quality of health care provided to enrollees. The program must include, at a minimum, systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory

requirements.

An HMO also must establish and maintain a quality improvement program to design, measure, assess, and improve the processes and outcomes of health care as identified in the program. This program must be under the direction of the HMO's medical director and include: a written statement of the program's objectives, lines of authority and accountability, evaluation tools, and performance improvement activities; an annual effectiveness review of the program; and a written quality improvement plan that, at least, describes how the HMO analyzes both the processes and outcomes of care, identifies the targeted diagnoses and treatments to be reviewed each year, uses a range of appropriate methods to analyze quality, compares program findings with past performance and internal goals and external standards, measures the performance of affiliated providers, and conducts peer review activities.

An HMO must make these programs available as prescribed by the Commissioner.

Credentialing Verification

The bill requires an HMO to establish written policies and procedures for credentialing verification of all health professionals with whom the HMO contracts, and to apply those standards consistently. (The bill defines "credentialing verification" as the process of obtaining and verifying information about a health professional and evaluating him or her when the health professional applies to become a participating provider with an HMO.)

An HMO must verify the credentials of a health professional before entering into a contract with that person. The HMO's medical director or other designated health professional must be responsible for, and participate in, health professional credentialing verification.

An HMO also must establish a credentialing verification committee; make available for review by the applying health professional all application and credentialing verification policies and procedures; retain all records and documents relating to a health professional's credentialing verification process for at least two years; and keep confidential all information obtained in the process, except as otherwise provided by law.

In addition, an HMO must obtain primary verification of at least all of the following information about an applicant to become an affiliated provider with the HMO: current license to practice in this State and history of licensure; graduation from medical or other appropriate school; and, if applicable, current level of professional liability coverage, status of hospital privileges, specialty board certification status, current Drug Enforcement Agency (DEA) registration certificate, and completion of postgraduate training. (The bill defines "primary verification" as verification by an HMO of a health professional's credentials based upon evidence obtained from the issuing source of a credential.)

An HMO also must obtain, subject to either primary or secondary verification at its discretion, all of the following information about an applicant to become an affiliated provider with the HMO: the health professional's license history in this and all other states; the professional's malpractice history; and the professional's practice history. ("Secondary verification" means verification by an HMO of a health professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of a credential.)

At least every three years, an HMO must obtain primary verification of all of the following for a participating health care professional: current license to practice in this State and, if applicable, current level of professional liability coverage, status of hospital privileges, current DEA registration certificate, and specialty board certification status.

An HMO must require all participating providers to notify it of changes in the status of any of the items listed in these provisions at any time and identify for providers the individual to whom they should report changes in status.

As described in the bill, an HMO must give a health professional an opportunity to review and correct information submitted in support of his or her credentialing verification application.

If an HMO contracts to have another entity perform the credentialing functions, the Commissioner must hold the HMO responsible for monitoring the entity's activities and ensuring that the bill's requirements are met.

The bill specifies that nothing in the Code may be construed to require an HMO to select a provider as a participating provider solely because the provider meets the HMO's credentialing verification standards, or to prevent an HMO from using separate or additional criteria in selecting the health professionals with whom it contracts.

Contracting with Health Professionals & Providers

The bill provides that an HMO may contract with or employ health professionals on the basis of cost, quality, availability of services to the membership, conformity to the HMO's administrative procedures, and other factors relevant to delivery of economical, quality care, but may not discriminate solely on the basis of the class of health professionals to which a person belongs.

An HMO must enter into contracts with providers through which health care services are usually provided to enrollees under the HMO plan. An affiliated provider contract must prohibit the provider from seeking payment from the enrollee for services pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments directly from enrollees. An affiliated provider contract must contain provisions ensuring that: the provider meets applicable licensure or certification standards; the HMO will have appropriate access to records or reports concerning services to its enrollees; and the provider cooperates with the HMO's quality assurance activities.

The Commissioner may waive the requirement that an HMO enter into contracts with providers through which health care services are usually provided to enrollees under the HMO plan, if an HMO demonstrates that it is unable to obtain a contract and accessibility to patient care would not be compromised. When 10% or more of an HMO's elective inpatient admissions, or projected admissions for a new HMO, occur in hospitals with which the HMO does not have contracts or agreements that protect enrollees from liability for authorized admissions and services, the HMO may be required to maintain a hospital reserve fund equal to three months' projected claims from those hospitals.

The bill requires an HMO to submit to the Commissioner for approval standard contract formats proposed for use with its affiliated providers and any substantive changes to those contracts. The format or change will be considered approved 30 days after filing unless it is approved or disapproved within the 30 days.

An HMO or applicant must provide evidence that it has employed, or executed affiliation contracts with, a sufficient number of providers to enable it to deliver the health maintenance services it proposes to offer.

Sufficiency of Affiliated Providers

The bill requires an HMO to maintain contracts with the numbers and types of affiliated providers that are sufficient to assure that covered services are available to its enrollees without unreasonable delay. The Commissioner must determine what is sufficient. If an HMO has an insufficient number or type of participating providers to provide a covered benefit, the HMO must ensure that an enrollee obtains the benefit at no greater cost to him or her than if the benefit were obtained from participating providers, or make other arrangements acceptable to the Commissioner.

The bill also requires an HMO to establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees. In determining whether an HMO has complied with this requirement, the Commissioner must give due consideration to the relative availability of health care providers in the service area.

Open Enrollment Period

The bill recodified requirements that an HMO have an open enrollment period of at least 30 days once during each consecutive 12-month period. Previously, an HMO had to accept up to its capacity as determined by the organization and submitted to the DCH and the Insurance Bureau before the commencement of the enrollment period, individuals in the order in which they applied for enrollment.

Under the bill, an HMO must accept up to its capacity as determined by the organization and submitted to the Commissioner not less than 60 days before the commencement of the enrollment period, individuals in the order in which they apply.

Under the bill, if an HMO enrolls individuals who are not members of a group, the HMO may rate this nongroup membership on the basis of actual and credible loss experience. (Previously, an HMO could rate nongroup membership on this basis or on the basis of reasonably anticipated experience in the case of new coverages.) The bill also deleted a provision that the contract offered to nongroup members had to include at a minimum primary health maintenance services and could include basic health services and additional services if the HMO so elected.

Medically Necessary Services

The bill prohibits an HMO from using any financial incentive or making any payment to a health professional that acts directly or indirectly as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services. The bill provides that this does not prohibit payment arrangements that are not tied to specific medical decisions or prohibit the use of risk sharing as otherwise authorized in Chapter 35.

Net Worth Requirements

Previously, an HMO had to have a net worth of $500,000 excluding land, buildings, and equipment, or $1,000,000 including land, buildings, and equipment.

Under the bill, an HMO applying for a certificate of authority on or after the bill's effective date, and an HMO wishing to maintain a certificate of authority after December 31, 2003, must possess and maintain unimpaired net worth in an amount determined adequate by the Commissioner to comply with Section 403 of the Insurance Code, but not less than the amount described below:

-- For an HMO that contracts or employs providers in numbers sufficient to provide 90% of its benefit payout, minimum net worth is the greatest of: $1,500,000; 4% of the HMO's subscription revenue; or three months' uncovered expenditures.
-- For an HMO that does not contract or employ providers in numbers sufficient to provide 90% of its benefit payout, minimum net worth is the greatest of: $3,000,000; 10% of the HMO's subscription revenue; or three months' uncovered expenditures.

The bill requires the Commissioner to take into account the risk-based capital requirements as developed by the National Association of Insurance Commissioners in order to determine adequate compliance with Section 403. (Under Section 403, a domestic, foreign, or alien insurer may not be authorized to do business in this State or continue to be authorized to do business in this State if the insurer is not or does not continue to be safe, reliable, and entitled to public confidence.)

An HMO licensed under Part 210 of the Public Health Code that automatically receives a certificate of authority under the bill, must possess and maintain unimpaired net worth as required under Part 210 until December 31, 2003, or until the HMO attains a level of net worth as provided above, whichever is earlier. At the time the HMO attains the prescribed level of net worth, it must continue to maintain that level.

Minimum Deposit Requirements

Previously, an applicant for licensure under Part 210 had to make a deposit of $100,000 with the State Treasurer or with a Federally or State-chartered financial institution under a trust indenture acceptable to the Commissioner for the sole benefit of the subscribers and enrollees in case of insolvency.

Under the bill, an HMO applying for a certificate of authority on or after the bill's effective date and an HMO wishing to maintain a certificate of authority after December 31, 2001, must possess and maintain a deposit in an amount determined adequate by the Commissioner to continue to comply with Section 403, but not less than $100,000 plus 5% of annual subscription revenue up to a $1,000,000 maximum deposit. The deposit must be made with the State Treasurer or a Federally or State-chartered financial institution, as already provided.

An HMO licensed under Part 210 that automatically receives a certificate of authority under the bill, must possess and maintain a deposit as required under Part 210 until December 31, 2001, or until the HMO attains a level of net worth as provided above, whichever is earlier. At the time the HMO attains the prescribed level of deposit, it must continue to maintain that level.

Financial Plan

The bill requires an HMO to maintain a financial plan evaluating, at a minimum, cash flow needs and adequacy of working capital. The plan must do all of the following:

-- Demonstrate compliance with all HMO financial requirements provided for in Chapter 35.
-- Identify the means of achieving and maintaining

a positive cash flow, including provisions for retirement of existing or proposed indebtedness.
-- Provide for adequate working capital, which may not be negative at any time.

The Commissioner may establish a minimum working capital requirement for an HMO to ensure the prompt payment of liabilities.

Change in Operations

The bill requires an HMO to file notice with the Commissioner of any substantive change in operations within 30 days after the change. A substantive change in operations includes, but is not limited to, any of the following:

-- A change in the location of corporate offices.
-- A change in the HMO's articles of incorporation or bylaws.
-- A change in contractual arrangements under which the HMO is managed.
-- A change in the HMO's officers or directors.

In addition to the notification, the HMO must file a disclosure statement for each newly appointed or elected officer or director.

Reinsurance or Self-Insurance

The bill requires an HMO to obtain a reinsurance contract or establish a plan of self-insurance as necessary to ensure solvency or to protect subscribers in the event of insolvency. A reinsurance contract must be with an insurer authorized or eligible to transact insurance in Michigan.

A reinsurance contract or plan must be filed with the Commissioner within 30 days after its finalization. The contract or plan must state clearly all services to be received by the HMO. It will be considered approved 30 days after its filing unless disapproved in writing before the 30 days expire.

An HMO also must maintain insurance coverage to protect the organization. The coverage must include, at least, fire, theft, fidelity, general liability, errors and omissions, director's and officer's liability coverage, and malpractice insurances. An HMO must obtain the Commissioner's approval before self-insuring for these coverages.

Plan of Insolvency

The bill requires an HMO to have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to any member who is confined on the date of insolvency in an inpatient facility until his or her discharge. Continuation of benefits in the event of insolvency will be satisfied if the HMO has at least one of the following, as approved by the Commissioner:

-- A financial guarantee contract insured by a surety bond issued by an independent insurer with a secure rating from a rating agency.
-- A reinsurance contract issued by an authorized or eligible insurer to cover the expenses to be paid for continued benefits after an insolvency.
-- A contract between the HMO and its affiliated providers providing for the continuation of provider services in the event of the HMO's insolvency. The contract must provide a mechanism for appropriate sharing by the HMO of the continuation of provider services as approved by the Commissioner, and may not provide that continuation is solely the responsibility of affiliated providers.
-- An irrevocable letter of credit.
-- An insolvency reserve account established with a Federal or State-chartered financial institution under a trust indenture acceptable to the Commissioner for the sole benefit of subscribers and enrollees, equal to three months' premium income.

HMO Insolvency

Under the bill, if an HMO becomes insolvent, upon the Commissioner's order all other HMOs and health insurers that participated in the enrollment process with the insolvent HMO at a group's last regular enrollment period, must offer the insolvent HMO's and health insurer's group enrollees a 30-day enrollment period beginning on the date of the Commissioner's order. Each HMO and health insurer must offer the insolvent HMO's enrollees the same coverages and rates that it offered to them at its last regular enrollment period.

If no other HMO or health insurer has been offered to some groups enrolled in the insolvent HMO, or if the Commissioner determines that the other HMOs or health insurers lack sufficient health care delivery resources to assure that the health care services will be available and accessible to all of the group enrollees of the insolvent HMO, the Commissioner must equitably allocate the insolvent HMO's group contracts for these groups among all HMOs operating within a portion of the insolvent HMO's service area. Each HMO to which a group or groups are allocated must offer the group or groups the HMO's existing coverage that is most similar to each group's coverage with the insolvent HMO at rates determined in accordance with the successor HMO's existing rating methodology.

The Commissioner also must equitably allocate the insolvent HMO's nongroup enrollees who are unable to obtain other coverage among all HMOs operating within a portion of the insolvent HMO's service area. Each HMO to which nongroup enrollees are allocated must offer them the HMO's existing

coverage without a preexisting condition limitation for individual or conversion coverage as determined by the enrollee's type of coverage in the insolvent HMO at rates determined in accordance with the successor HMO's existing rating methodology. Successor HMOs that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

If an HMO that contracts with a State-funded health care program becomes insolvent, the Commissioner must inform the State agency responsible for the program of the insolvency. Enrollees of the program must be reassigned in accordance with State and Federal statutes governing the particular program, notwithstanding any of the above provisions.

Cancellation

Under the bill, in addition to other rights available to revoke an offer, a nongroup subscriber may cancel an HMO contract within 72 hours after signing. Within 30 days of receiving the notice of cancellation, the HMO must refund any deposit or prepayment made. A nongroup subscriber will be responsible for payment of reasonable fees for any services received during the 72 hours. Fees may be deducted from the deposit or prepayment before the refund is made.

Cancellation will occur when written notice is mailed or hand-delivered to the HMO or its agent or representative. Notice of cancellation will be sufficient if it indicates the person's intention not to be bound by the contract or application.

An HMO must delineate clearly all conditions under which it may cancel coverage for an enrollee. A health maintenance contract for nongroup subscribers must specify an enrollee's rights and options in the case of a proposed amendment or change in the contract or the rate charged. Continued prepayment by a subscriber during the period of appeal, and while an appeal is in progress, will not constitute acceptance of the proposed amendment or rate change.

Assumption of Financial Risk

Except as provided in Section 3515(2) (which concerns nominal copayments for specific services), the bill requires an HMO to assume full financial risk on a prospective basis for the provision of health maintenance services. The HMO, however, may do any of the following:

-- Require an affiliated provider to assume financial risk under the terms of its contract.
-- Obtain insurance.
-- Make other arrangements for the cost of providing to an enrollee health maintenance services whose aggregate value is more than $5,000 in a year for that enrollee.

If the HMO requires an affiliated provider to assume financial risk under the terms of its contract, the contract must require the HMO to pay the provider, including a subcontracted provider, directly or through a licensed third party administrator for health maintenance services provided to its enrollees. The contract also must require the HMO to keep all pooled funds and withhold amounts and account for them on its financial books and records and reconcile them at year end in accordance with the written agreement between the affiliated provider and the HMO.

Grievance Procedures

Under the Insurance Code, each insurer must establish an internal formal grievance procedure for approval by the Insurance Bureau for persons covered under a disability policy or certificate. The bill extends this requirement to HMOs, and refers to approval by the Commissioner. Currently, the grievance procedure must provide for notification to the insured person of the results of the insurer's investigation and the person's right to review of the grievance by the Commissioner. Under the bill, this applies through September 30, 2000. Beginning October 1, 2000, the grievance procedure must provide for notification of the person's right to review by an independent review organization under the Patient's Right to Independent Review Act (enacted by House Bill 5576).

In addition, the grievance procedure had to provide summary data on the number and types of complaints filed. The bill requires summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, these summary data for the prior calendar year must be filed annually with the Commissioner.

Previously, the grievance procedure had to provide that when an adverse determination was made, a written statement containing the reasons for the adverse determination would be provided to the insured person, and that a notification of the grievance procedures would be provided to the person when he or she contested an adverse determination. Under the bill, the grievance procedure must provide that, when an adverse determination is made, a written statement containing the reasons for the determination will be provided to the insured person or enrollee along with written notifications as required under the Patient's Right to Independent Review Act.

In addition, the grievance procedure previously had to provide that a final determination would be made in writing by the insurer within 90 calendar days after a formal grievance was submitted in writing by the insured person. The bill shortened that period to 35 calendar days. As previously allowed, the timing for this period may be tolled for any period of time the insured person (or enrollee) is permitted to take under the grievance procedure. The bill also allows the timing for the 35-calendar-day period to be tolled for up to 10 business days if the insurer or HMO has not received requested information from a health care facility or health professional.

Under the bill, an expedited grievance procedure applies if a grievance is submitted and a physician substantiates that the time frame for a standard grievance would seriously jeopardize the life or health of the insured or enrollee or would jeopardize his or her ability to regain maximum function. Previously, a physician had to substantiate that the standard time frame would acutely jeopardize the life of the insured.

The grievance procedure previously had to provide that the insurer would make an initial determination within 72 days after receiving an expedited grievance; within three business days after the initial determination, the insured or a person authorized to act on his or her behalf could request further review by the insurer or a determination of the matter by the Commissioner; and the insurer would make a final determination within 30 days after receiving the request for further review. Within 10 days after receiving a final determination, the insured or authorized person could request a determination of the matter by the Commissioner. The bill, instead, requires the grievance procedure to provide that the insurer or HMO will make a determination within 72 hours after receiving an expedited grievance. Within 10 days after receiving the determination, the insured or enrollee may request a determination of the matter by the Commissioner through September 30, 2000, and beginning October 1, 2000, by an independent review organization under the Patient's Right to Independent Review Act.

Other Provisions

The bill permits an HMO, with the Commissioner's prior approval, to acquire obligations from another managed care facility. The Commissioner may not grant prior approval unless he or she determines that the transaction will not jeopardize the HMO's financial security.

The bill allows an HMO to hold and maintain legal title to all assets, including cash and investments. Health maintenance organization funds and assets may not be commingled with affiliates or other entities in pooling or cash management type arrangements. All HMO assets must be held separate from all other activities of other members in a holding company system.

The bill specifies that an HMO is not precluded from meeting the requirements of, receiving money from, and enrolling beneficiaries or recipients of, State and Federal health programs.

MCL 500.102 et al.

Legislative Analyst: S. Lowe

FISCAL IMPACT

The bill restates grievance procedures enacted by House Bill 5576, increases HMO solvency requirements, and moves the full control for these entities from the Public Health Code (DCH) to the Commissioner of the Office of Financial and Insurance Services (DCIS). Other than possible increased costs for that office, there appears to be no reason for increased costs to State or local entities.

The bill will increase the costs to the Office of Financial Services, which will be required to administer all of the regulation of HMOs, which were formerly regulated by the DCIS and the Department of Community Health. The fee structure that is outlined in the bill may offset the majority of the costs associated with these additional responsibilities, but according to the DCIS, final costs and total impact are indeterminate.

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