THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

CHAPTER 35
HEALTH MAINTENANCE ORGANIZATIONS

500.3501 Definitions.

Sec. 3501. As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or any other institution, organization, or person that has entered into a participating provider contract, directly or indirectly, with a health maintenance organization to render 1 or more health services to an enrollee. Affiliated provider includes a person described in this subdivision that has entered into a written arrangement with another person, including, but not limited to, a physician hospital organization or physician organization, that contracts directly with a health maintenance organization.

(b) "Basic health services" means medically necessary health services that health maintenance organizations must offer to large employers in at least 1 health maintenance contract. Basic health services include all of the following:

(*i*) Physician services including primary care and specialty care.

(*ii*) Ambulatory services.

(*iii*) Inpatient hospital services.

(*iv*) Emergency health services.

(*v*) Mental health and substance use disorder services.

(*vi*) Diagnostic laboratory and diagnostic and therapeutic radiological services.

(*vii*) Home health services.

(*viii*) Preventive health services.

(c) "Credentialing verification" means the process of obtaining and verifying information about a health professional and evaluating the health professional when the health professional applies to become a participating provider with a health maintenance organization.

(d) "Health maintenance contract" means a contract between a health maintenance organization and a subscriber or group of subscribers to provide or arrange for the provision of health services within the health maintenance organization's service area. Health maintenance contract includes a prudent purchaser agreement under section 3405.

(e) "Health maintenance organization" means a person that, among other things, does the following:

(*i*) Delivers health services that are medically necessary to enrollees under the terms of its health maintenance contract, directly or through contracts with affiliated providers, in exchange for a fixed prepaid sum or per capita prepayment, without regard to the frequency, extent, or kind of health services.

(*ii*) Is responsible for the availability, accessibility, and quality of the health services provided.

(f) "Health professional" means an individual licensed, certified, or authorized in accordance with state law to practice a health profession in his or her respective state.

(g) "Health services" means services provided to enrollees of a health maintenance organization under their health maintenance contract.

(h) "Service area" means a defined geographical area in which covered health services are generally available and readily accessible to enrollees and where health maintenance organizations may market their contracts.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

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500.3503 Applicability of provisions to health maintenance organization.

Sec. 3503. (1) Unless specifically excluded, or otherwise specifically provided for in this chapter, all of the provisions of this act that apply to a domestic insurer authorized to issue a health insurance policy apply to a health maintenance organization.

(2) Sections 408, 410, 411, and 901, and chapters 77 and 79 do not apply to a health maintenance organization.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2006, Act 366, Imd. Eff. Sept. 18, 2006;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3505 Health maintenance contract; use of descriptive words; restrictions.

Sec. 3505. (1) A health maintenance organization shall not issue a health maintenance contract before it receives a certificate of authority under this act.

(2) A person shall not use the term health maintenance organization to describe or refer to a person, and a person shall not use any other descriptive words that may mislead, deceive, or imply that it is a health maintenance organization, unless the person described or referred to has a certificate of authority as a health maintenance organization under this act.

(3) Except as otherwise provided in this subsection, a health maintenance organization shall not use in its name, contracts, or literature the words "insurance", "casualty", "surety", or "mutual" or any other words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of an insurance or surety corporation doing business in this state. A health maintenance organization may use a name or description that is similar to its affiliate.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3507 Authorizing and regulating health maintenance organization; establishment of system by director.

Sec. 3507. The director shall establish a system of authorizing and regulating health maintenance organizations in this state to protect and promote the public health through the assurance that the organizations provide all of the following:

(a) An acceptable quality of health care by qualified personnel.

(b) Health care facilities, equipment, and personnel that may reasonably be required to economically provide health services.

(c) Operational arrangements that integrate the delivery of various services.

(d) Financially sound prepayment plans for meeting health care costs.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3508 Quality assessment program; quality improvement program.

Sec. 3508. (1) A health maintenance organization shall develop and maintain a quality assessment program that includes, at a minimum, systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements.

(2) A health maintenance organization shall 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. A health maintenance organization shall place the quality improvement program under the direction of its medical director and include all of the following in the program:

(a) A written statement of the program's objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, and performance improvement activities.

(b) An annual effectiveness review of the program.

(c) A written quality improvement plan that, at a minimum, describes how the health maintenance organization 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.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3509 Certificate of authority; application; form; limitation; change of service area.

Sec. 3509. (1) An application to the director for a certificate of authority must be on a form prescribed and provided by the director.

(2) A certificate of authority issued to a health maintenance organization under this act is limited to the service area described in the application on which the certificate of authority was issued. Approved parts of a health maintenance organization's service area are not required to be contiguous.

(3) A health maintenance organization seeking to change the approved service area shall submit an

application to change service area to the director and shall not change the service area until approval is received. The director shall specify the information required to be in the application under this subsection.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3511 Governing body; election of enrollee board members; requirements; meetings.

Sec. 3511. (1) A health maintenance organization's governing body must include no less than 1 individual who represents the health maintenance organization's membership.

(2) A health maintenance organization that is under a contract with this state to provide medical services authorized under subchapter XIX or XXI of the social security act, 42 USC 1396 to 1396w-5 and 1397aa to 1397mm, shall comply with either of the following requirements:

(a) A minimum of 1/3 of its governing body must be representatives of its membership consisting of enrollees of the organization who are not compensated officers, employees, or other individuals responsible for the conduct of, or financially interested in, the organization's affairs.

(b) The health maintenance organization must establish a consumer advisory council that reports to the governing body. The consumer advisory council must include at least 1 enrollee, 1 family member or legal guardian of an enrollee, and 1 consumer advocate.

(3) A health maintenance organization's governing body shall meet at least quarterly unless specifically exempted from this requirement by the director.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3513 Health maintenance organization operations; regulation by director; incorporation as legal entity.

Sec. 3513. (1) The director shall regulate health delivery aspects of health maintenance organization operations to ensure that health maintenance organizations are capable of providing care and services promptly, appropriately, and in a manner that ensures continuity and acceptable quality of health care. The director shall encourage health maintenance organizations to use a wide variety of health-related disciplines and facilities and to develop services that contribute to the prevention of disease and disability and the restoration of health.

(2) The director shall ensure that health maintenance organizations operate in the interest of enrollees consistent with overall health care cost containment while delivering acceptable quality of care and services that are available and accessible to enrollees with appropriate administrative costs and health care provider incentives. A health maintenance organization shall do all of the following:

(a) Provide, as promptly as appropriate, health services in a manner that ensures continuity and imparts quality health care under conditions the director considers to be in the public interest.

(b) Provide health services within its service area that are available and accessible to enrollees 24 hours a day and 7 days a week for the treatment of emergency episodes of illness or injury.

(c) Provide that reasonable provisions exist for an enrollee to obtain emergency health services both within and outside of its service area.

(3) A health maintenance organization must be incorporated as a distinct legal entity under the business corporation act, 1972 PA 284, MCL 450.1101 to 450.2098, the nonprofit corporation act, 1982 PA 162, MCL 450.2101 to 450.3192, or the Michigan limited liability company act, 1993 PA 23, MCL 450.4101 to 450.5200.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3515 Additional health services; deductibles; copayments; "preventive health care services" defined; partial payment from government or private person.

Sec. 3515. (1) A health maintenance organization may provide additional health services or any other related health care service or treatment not required under this act.

(2) A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts that include copayments, stated as dollar amounts for the cost of covered services, and coinsurance, stated as percentages for the cost of covered

services. This subsection does not limit the director's authority to regulate and establish fair, sound, and reasonable copayment and coinsurance limits including out of pocket maximums.

(3) A health maintenance organization shall not require that contributions be made to a deductible for preventive health care services. As used in this subsection, "preventive health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability.

(4) A health maintenance organization may accept from governmental agencies and from private persons payments covering any part of the cost of health maintenance contracts.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 97, Eff. Aug. 1, 2016;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3517 Healthy lifestyle programs; emergency or out-of-area service; payment of expenses or fees.

Sec. 3517. (1) A health maintenance contract shall not provide for payment of cash or other material benefit to an enrollee other than as permitted under the law of this state or as approved by the director under section 2236.

(2) Subsection (1) does not prohibit a health maintenance organization from promoting optimum health by offering to all currently enrolled subscribers or to all currently covered enrollees 1 or more healthy lifestyle programs. As used in this subsection, "healthy lifestyle program" means a program recognized by a health maintenance organization that enhances health, educates enrollees on health-related matters, or reduces risk of disease, including, but not limited to, promoting nutrition and physical exercise and compliance with disease management programs and preventive service guidelines that are supported by evidence-based medical practice. A healthy lifestyle program may include other requirements in addition to those that enhance health, educate enrollees on health-related matters, or reduce risk of disease if the healthy lifestyle program, taken as a whole, meets the intent of this subsection. Subsection (1) does not prohibit a health maintenance organization from offering a currently enrolled subscriber or currently covered enrollee goods, vouchers, or equipment that supports achieving optimal health goals. An offering of goods, vouchers, or equipment under this subsection is not a violation of subsection (1) and is not valuable consideration, a material benefit, a gift, a rebate, or an inducement under this act.

(3) For an emergency episode of illness or injury that requires immediate treatment before it can be secured through the health maintenance organization, or for an out-of-area service specifically authorized by the health maintenance organization, an enrollee may use a provider in or outside of this state not normally engaged by the health maintenance organization to render service to its enrollees. The health maintenance organization shall pay reasonable expenses or fees to the provider or enrollee as appropriate in an individual case. These transactions are not acts of insurance and, except as provided in this chapter and section 3406k, are not otherwise subject to this act.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3519 Contract and contract rates; fairness; rate differential; basic health services to large employers required.

Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any deductibles, copayments, and coinsurances, between the organization and its subscribers must be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts must not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates must not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The director may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverages. A healthy lifestyle program as defined in section 3517(2) is not subject to the director's approval under this subsection and is not required to

be supported by sound actuarial principles, a reasonable classification system, or be related to actual and credible loss statistics or reasonably anticipated experience for new coverages.

(3) A health maintenance organization contract shall offer basic health services to large employers in at least 1 health maintenance contract.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3521 Prepayment rates; filing and approval of methodology; schedule.

Sec. 3521. (1) The methodology used to determine prepayment rates by category rates charged by the health maintenance organization and any changes to either the methodology or the rates shall be filed with and approved by the commissioner before becoming effective.

(2) A health maintenance organization shall submit supporting data used in the development of a prepayment rate or rating methodology and all other data sufficient to establish the financial soundness of the prepayment plan or rating methodology.

(3) The commissioner may annually require a schedule of rates for all subscriber contracts and riders. All submissions shall note changes of rates previously filed or approved.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

500.3523 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to provisions included in health maintenance contract.

Popular name: Act 218

Popular name: HMO

500.3525 Proposal to revise contract or rate; approval of commissioner; approval with modifications; hearing; disposition; exception; notice.

Sec. 3525. (1) Except as otherwise provided in subsection (2), if a health maintenance organization desires to change a contract it offers to enrollees or desires to change a rate charged, a copy of the proposed revised contract or rate shall be filed with the commissioner and shall not take effect until 60 days after the filing, unless the commissioner approves the change in writing before the expiration of 60 days after the filing. If the commissioner considers that the proposed revised contract or rate is illegal or unreasonable in relation to the services provided, the commissioner, not more than 60 days after the proposed revised contract or rate is filed, shall notify the organization in writing, specifying the reasons for disapproval or for approval with modifications. For an approval with modifications, the notice shall specify what modifications in the filing are required for approval, the reasons for the modifications, and that the filing becomes effective after the modifications are made and approved by the commissioner. The commissioner shall schedule a hearing not more than 30 days after receipt of a written request from the health maintenance organization, and the revised contract or rate shall not take effect until approved by the commissioner after the hearing. Within 30 days after the hearing, the commissioner shall notify the organization in writing of the disposition of the proposed revised contract or rate, together with the commissioner's findings of fact and conclusions.

(2) If the revised contract or rate is the result of collective bargaining and affects only the members of the groups engaged in the collective bargaining, subsection (1) does not apply but the revised contract or rate shall be immediately filed with the commissioner.

(3) Except as provided in this subsection with respect to health maintenance contracts issued in connection with state and federal health programs under section 3571, not less than 30 days before the effective date of a proposed change in a health maintenance contract or the rate charged, the health maintenance organization shall issue to each subscriber or group of subscribers who will be affected by the proposed change a clear written statement stating the extent and nature of the proposed change. With respect to health maintenance contracts issued in connection with state and federal health programs under section 3571, advance notice is not required if the change in a health maintenance contract or rate arises from a change in the law, a state or federal administrative order, or an executive order and the change does not provide for a reasonable period of time for a health maintenance organization to give the required notice. In that case, the health maintenance organization shall provide notice within 30 days after the effective date of the change. If the commissioner has approved a proposed change in a contract or rate in writing before the expiration of 60 days after the date of filing, the organization immediately shall notify each subscriber or group of subscribers who will be

affected by the proposed change.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2010, Act 172, Imd. Eff. Sept. 30, 2010.

Popular name: Act 218

Popular name: HMO

500.3527 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to performance of obligations under health maintenance contract.

Popular name: Act 218

Popular name: HMO

500.3528 Health maintenance organization; credentialing verification; accreditation by nationally recognized accredited body.

Sec. 3528. (1) A health maintenance organization shall establish written policies and procedures for credentialing verification of all health professionals with whom the health maintenance organization contracts. A health maintenance organization shall apply these standards consistently. This act does not require a health maintenance organization to select a provider as an affiliated provider solely because the provider meets the health maintenance organization's credentialing verification standards. This act does not prevent a health maintenance organization from using separate or additional criteria in selecting the health professionals with whom it contracts.

(2) A health maintenance organization is considered to meet the requirements of this section if the health maintenance organization is accredited by a nationally recognized accredited body approved by the director. As used in this subsection, "nationally recognized accredited body" includes the National Committee for Quality Assurance.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3529 Affiliated provider contracts; collection of payments from enrollees; contract provisions; waiver of requirement under subsection (2); contract format; evidence of sufficient number of providers.

Sec. 3529. (1) A health maintenance organization may contract with or employ health professionals on the basis of cost, quality, availability of services to the membership, conformity to the administrative procedures of the health maintenance organization, and other factors relevant to delivery of economical, quality care, but shall not discriminate solely on the basis of the class of health professionals to which the health professional belongs.

(2) A health maintenance organization shall enter into contracts with providers through which health care services are usually provided to enrollees under the health maintenance organization plan.

(3) An affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments, coinsurances, and deductibles directly from enrollees.

(4) An affiliated provider contract shall contain provisions assuring all of the following:

(a) The provider meets applicable licensure or certification requirements.

(b) Appropriate access by the health maintenance organization to records or reports concerning services to its enrollees.

(c) The provider cooperates with the health maintenance organization's quality assurance activities.

(5) The commissioner may waive the contract requirement under subsection (2) if a health maintenance organization has demonstrated that it is unable to obtain a contract and accessibility to patient care would not be compromised. When 10% or more of a health maintenance organization's elective inpatient admissions, or projected admissions for a new health maintenance organization, occur in hospitals with which the health maintenance organization does not have contracts or agreements that protect enrollees from liability for authorized admissions and services, the health maintenance organization may be required to maintain a hospital reserve fund equal to 3 months' projected claims from such hospitals.

(6) A health maintenance organization shall submit to the commissioner for approval standard contract formats proposed for use with its affiliated providers and any substantive changes to those contracts. The contract format or change is considered approved 30 days after filing unless approved or disapproved within the 30 days. As used in this subsection, "substantive changes to contract formats" means a change to a

provider contract that alters the method of payment to a provider, alters the risk assumed by each party to the contract, or affects a provision required by law.

(7) A health maintenance organization or applicant shall provide evidence that it has employed, or has executed affiliation contracts with, a sufficient number of providers to enable it to deliver the health maintenance services it proposes to offer.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005.

Popular name: Act 218

Popular name: HMO

500.3530 Availability of covered services; assurance; establishment and maintenance of proximity.

Sec. 3530. (1) A health maintenance organization shall maintain contracts with those numbers and those types of affiliated providers that are sufficient to assure that covered services are available to its enrollees without unreasonable delay. The commissioner shall determine what is sufficient as provided in this section and as may be established by reference to reasonable criteria used by the health maintenance organization, including, but not limited to, provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(2) If a health maintenance organization has an insufficient number or type of participating providers to provide a covered benefit, the health maintenance organization shall ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the commissioner.

(3) A health maintenance organization shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees. In determining whether a health maintenance organization has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

500.3531 Contracts with health care providers to become affiliated providers; requirements; standards; filing; duplicative standards; notice procedures; provider application period; approval or rejection as affiliated provider; termination of contract; providing information to insurer.

Sec. 3531. (1) This section applies if a health maintenance organization contracts with health care providers to become affiliated providers or offers a prudent purchaser contract.

(2) A health maintenance organization may enter into a contract with 1 or more health care providers to control health care costs, assure appropriate utilization of health maintenance services, and maintain quality of health care. The health maintenance organization may limit the number of contracts entered into under this section if the number of contracts is sufficient to assure reasonable levels of access to health maintenance services for recipients of those services. The number of contracts authorized by this section that are necessary to assure reasonable levels of access to health maintenance services for recipients shall be determined by the health maintenance organization as approved by the commissioner under this chapter. However, the health maintenance organization shall offer a contract, comparable to those contracts entered into with other affiliated providers, to at least 1 health care provider that provides the applicable health maintenance services and is located within a reasonable distance from the recipients of those health maintenance services, if a health care provider that provides the applicable health maintenance services is located within that reasonable distance.

(3) A health maintenance organization shall give all health care providers that provide the applicable health maintenance services and are located in the geographic area served by the health maintenance organization an opportunity to apply to the health maintenance organization to become an affiliated provider.

(4) A contract shall be based upon the following written standards which shall be filed by the health maintenance organization with the commissioner on a form and in a manner that is uniformly developed and applied by the commissioner:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards considered appropriate by the health maintenance organization.

(5) If the commissioner determines that standards under subsection (4) are duplicative of standards already filed by the health maintenance organization, those duplicative standards need not be filed under subsection (4).

(6) A health maintenance organization shall develop and institute procedures that are designed to notify health care providers that provide the applicable health maintenance services and are located in the geographic area served by the organization of the acceptance of applications for a provider panel. The procedures shall include the giving of notice to those providers upon request and shall include publication in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the initial provider application period.

(7) A health maintenance organization shall provide for an initial 60-day provider application period during which providers may apply to the health maintenance organization to become affiliated providers. A health maintenance organization that has entered into a contract with an affiliated provider shall provide, at least once every 4 years, for a 60-day provider application period during which a provider may apply to the organization to become an affiliated provider. Notice of this provider application period shall be given to providers upon request and shall be published in a newspaper with general circulation in the geographic area served by the organization at least 30 days before the commencement of the provider application period. Upon receipt of a request by a health care provider, the organization shall provide the written standards required under this chapter to the health care provider. Within 90 days after the close of a provider application period, or within 30 days following the completion of the applicable physician credentialing process, whichever is later, a health maintenance organization shall notify an applicant in writing as to whether the application to become an affiliated provider has been accepted or rejected. If an applicant has been rejected, the health maintenance organization shall state in writing the reasons for rejection, citing 1 or more of the standards.

(8) A health care provider whose contract as an affiliated provider is terminated shall be provided upon request with a written explanation by the organization of the reasons for the termination.

(9) A health maintenance organization that is providing prudent purchaser agreement services to an insurer shall provide the insurer on a timely basis with information requested by the insurer that the organization has and that the insurer needs to comply with section 2212.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000.

Popular name: Act 218

Popular name: HMO

500.3533 Prudent purchaser contracts; reimbursement for unauthorized services or services by nonaffiliated providers.

Sec. 3533. Subject to section 3405, a health maintenance organization may offer prudent purchaser contracts to groups or individuals and in conjunction with those contracts a health maintenance organization may pay or may reimburse enrollees, or may contract with another person to pay or reimburse enrollees, for unauthorized services or for services by nonaffiliated providers in accordance with the terms of the contract and subject to copayments, coinsurances, deductibles, or other financial penalties designed to encourage enrollees to obtain services from affiliated providers.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3535 Solicitation or advertising.

Sec. 3535. Solicitation of enrollees or advertising of the services, charges, or other nonprofessional aspects of the health maintenance organization's operation under this section is not in violation of laws relating to solicitation or advertising by health professionals. A health maintenance organization shall not, in its solicitation or advertising allowed under this section, include advertising that makes a qualitative judgment as to a health professional who provides services for the health maintenance organization. A health maintenance organization shall not, in its solicitation or advertising allowed under this section, offer a material benefit or other thing of value as an inducement to prospective subscribers other than the services of the health maintenance organization.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3537 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to open enrollment period for health maintenance organizations.

Popular name: Act 218

Popular name: HMO

500.3539 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to exclusions and limitations contained in nongroup contract and renewal requirements.

Popular name: Act 218

Popular name: HMO

500.3541 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to health professional advocating on behalf of enrollee.

Popular name: Act 218

Popular name: HMO

500.3542 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to prohibition against use of financial inducement or payment to health professional.

Popular name: Act 218

Popular name: HMO

500.3543 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to owning or investing in third party administrator.

Popular name: Act 218

Popular name: HMO

500.3544 Noninsured benefit plan; processing and payment of claims.

Sec. 3544. (1) A health maintenance organization may process and pay claims on behalf of a noninsured benefit plan only after the health maintenance organization has received adequate money from the noninsured benefit plan sponsor to fully cover the claim payments.

(2) As used in this section, "noninsured benefit plan" means that term as defined in section 5208.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3545 Acquisition of obligations from another managed care entity.

Sec. 3545. With the director's prior approval, a health maintenance organization may acquire obligations from another managed care entity. The director shall not grant prior approval unless the director determines that the transaction will not jeopardize the health maintenance organization's financial security.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3547 Health care service operations; visitation or examination by director; consultation with enrollees; authority; access to information relating to delivery of services; submission of information regarding proposed contract.

Sec. 3547. (1) The director at any time may visit or examine the health care service operations of a health maintenance organization and consult with enrollees to the extent necessary to carry out the intent of this act.

(2) The director has the authority granted under chapter 2 with regard to a health maintenance organization under this chapter.

(3) A health maintenance organization shall give the director access to all information of the health maintenance organization relating to the delivery of health services, including, but not limited to books, papers, computer databases, and documents, in a manner that preserves the confidentiality of the health records of individual enrollees.

(4) At the request of the director, a health maintenance organization shall submit information regarding a

proposed contract between the health maintenance organization and an affiliated provider that the director considers necessary to ensure that the contract is in compliance with this act.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3548 Maintenance of books, records, files, and financial records; funds and assets.

Sec. 3548. (1) A health maintenance organization shall keep all of its books, records, and files at or under the control of its principal place of doing business in this state, and shall keep a record of all of its securities, notes, mortgages, or other evidences of indebtedness, representing investment of funds at its principal place of doing business in this state in the same manner as provided for in section 5256.

(2) A health maintenance organization shall maintain financial records for its health maintenance activities separate from the financial records of any other operation or activity.

(3) A health maintenance organization shall hold and maintain legal title to all assets, including cash and investments. A health maintenance organization shall not commingle funds or assets in pooling or cash management type arrangements with affiliates or other persons. A health maintenance organization shall hold all of its assets separate from all other activities of other members in a holding company system.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3549 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to notice to appropriate board by health maintenance organization as to disciplinary action.

Popular name: Act 218

Popular name: HMO

500.3551 Health maintenance organization; net worth.

Sec. 3551. (1) A health maintenance organization shall determine its minimum net worth using accounting procedures approved by the director. The accounting procedures must ensure that a health maintenance organization is financially and actuarially sound.

(2) To obtain or maintain a certificate of authority in this state, a health maintenance organization shall possess and maintain unimpaired net worth in an amount determined adequate by the director to continue to comply with section 403 but not in an amount less than the following, as applicable:

(a) For a health maintenance organization that contracts with or employs providers in numbers sufficient to provide 90% of the health maintenance organization's benefit payout, minimum net worth is the greatest of the following:

(*i*) $1,500,000.00.

(*ii*) Four percent of the health maintenance organization's subscription revenue.

(*iii*) Three months' uncovered expenditures.

(b) For a health maintenance organization that does not contract with or employ providers in numbers sufficient to provide 90% of the health maintenance organization's benefit payout, minimum net worth is the greatest of the following:

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

(*ii*) Ten percent of the health maintenance organization's subscription revenue.

(*iii*) Three months' uncovered expenditures.

(3) The director shall 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 this section.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3553 Certificate of authority; deposit requirements.

Sec. 3553. (1) To obtain or maintain a certificate of authority in this state, a health maintenance organization shall possess and maintain a deposit in an amount determined adequate by the director to continue to comply with section 403 but not less than $100,000.00 plus 5% of annual subscription revenue up to a $1,000,000.00 maximum deposit.

(2) A health maintenance organization shall make the deposit required under subsection (1) with the state treasurer or with a federal or state chartered financial institution under a trust indenture acceptable to the director for the sole benefit of the subscribers and enrollees in case of insolvency.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3555 Financial plan.

Sec. 3555. A health maintenance organization shall maintain a financial plan evaluating, at a minimum, cash flow needs and adequacy of working capital. The plan under this subsection must do all of the following:

(a) Demonstrate compliance with all health maintenance organization financial requirements provided for in this act.

(b) Provide for adequate working capital, which must not be negative at any time. The director may establish a minimum working capital requirement for a health maintenance organization to ensure the prompt payment of liabilities.

(c) Identify the means of achieving and maintaining a positive cash flow, including provisions for retirement of existing or proposed indebtedness.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3557 Notice of changes in operations.

Sec. 3557. A health maintenance organization shall file notice with the director of any substantive changes in operations within 30 days after the substantive change in operations occurs. A substantive change in operations includes, but is not limited to, any of the following:

(a) A change in the health maintenance organization's officers or directors. In addition to the notification, the health maintenance organization shall file a disclosure statement on a form prescribed by the director for each newly appointed or elected officer or director.

(b) A change in the location of corporate offices.

(c) A change in the organization's articles of incorporation or bylaws. A health maintenance organization shall include a copy of the revised articles of incorporation or bylaws with the notice.

(d) A change in contractual arrangements under which the health maintenance organization is managed.

(e) Any other significant change in operations.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3559 Reinsurance contract or plan of self-insurance; purpose; filing; approval; coverage.

Sec. 3559. (1) Subject to subsection (2), a health maintenance organization shall 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 that is authorized or eligible to transact insurance in this state.

(2) A health maintenance organization shall file a reinsurance contract or plan under subsection (1) for approval with the director within 30 days after the finalization of the contract or plan. A reinsurance contract or plan must clearly state all services to be received by the health maintenance organization. A reinsurance contract or plan is considered approved 30 days after it is filed with the director unless disapproved in writing by the director before the expiration of the 30 days.

(3) A health maintenance organization shall maintain insurance coverage to protect the health maintenance organization that includes, at a minimum, fire, theft, fidelity, general liability, errors and omissions, director's and officer's liability coverage, and malpractice insurance. A health maintenance organization shall obtain the director's prior approval before self-insuring for these coverages.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

Popular name: HMO

500.3561 Insolvency; continuation of benefits.

Sec. 3561. A health maintenance organization shall have a plan for handling insolvency that allows for continuation of benefits for the duration of the health maintenance contract period for which premiums have been paid and continuation of benefits to any enrollee who is confined on the date of insolvency in an inpatient facility until his or her discharge from the facility. Continuation of benefits in the event of insolvency is satisfied if the health maintenance organization has at least 1 of the following, as approved by the director:

(a) A financial guarantee contract insured by a surety bond issued by an independent insurer with a secure rating from a rating agency that meets the requirements of section 436a(1)(p).

(b) A reinsurance contract issued by an authorized or eligible insurer to cover the expenses to be paid for continued benefits after an insolvency.

(c) A contract between the health maintenance organization and its affiliated providers that provides for the continuation of provider services in the event of the health maintenance organization's insolvency. A health maintenance organization shall include in a contract under this subdivision a mechanism for appropriate sharing by the health maintenance organization of the continuation of provider services as approved by the director and shall not include a provision that continuation of provider services is solely the responsibility of the affiliated providers.

(d) An irrevocable letter of credit.

(e) An insolvency reserve account established with a federal or state chartered financial institution under a trust indenture acceptable to the director for the sole benefit of subscribers and enrollees, equal to 3 months' premium income.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3563 Insolvency; offer of enrollment by health insurers participating in enrollment process; allocation of group coverage to health maintenance organizations or insurers within service area; nongroup coverage; reassignment of enrollees of insolvent organization contracting with state funded health care program; substitute coverage under American health benefit exchange.

Sec. 3563. (1) If a health maintenance organization becomes insolvent, upon the director's order all other health insurers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the insolvent health maintenance organization's group enrollees a 30-day enrollment period beginning on the date of the director's order. Each health insurer shall offer the insolvent health maintenance organization's enrollees the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other health insurer was offered to some groups enrolled in an insolvent health maintenance organization, or if the director determines that the other health insurers lack sufficient health care delivery resources to ensure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, the director shall allocate equitably the insolvent health maintenance organization's group contracts for these groups among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are allocated under this subsection shall offer the group or groups the health maintenance organization's existing coverage that is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The director shall allocate equitably the insolvent health maintenance organization's nongroup enrollees who are unable to obtain other coverage among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated under this subsection shall offer the nongroup enrollees coverage without a preexisting condition limitation for individual coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates under the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations that do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into 1 group for rating and

coverage purposes.

(4) If a health maintenance organization that contracts with a state funded health care program becomes insolvent, the director shall inform the state agency responsible for the program of the insolvency. Notwithstanding any other provision of this section to the contrary, enrollees of an insolvent health maintenance organization covered by a state funded health care program may be reassigned under state and federal statutes governing the program.

(5) Notwithstanding any provision of this section to the contrary, an enrollee of an insolvent health maintenance organization who is eligible to obtain coverage as either an individual or a member of a small group under an American health benefit exchange established or operating in this state pursuant to the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, may obtain substitute coverage through the exchange.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3565 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to cancellation of contract with nongroup member enrollee by nongroup subscriber.

Popular name: Act 218

Popular name: HMO

500.3567 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to cancellation of contract with nongroup member enrollee by health maintenance organization.

Popular name: Act 218

Popular name: HMO

500.3569 Assumption of financial risk.

Sec. 3569. (1) Except as provided in section 3515(2), a health maintenance organization shall assume full financial risk on a prospective basis for the provision of health services under a health maintenance organization contract. A health maintenance organization may do any of the following:

(a) Require an affiliated provider to assume financial risk under the terms of its contract.

(b) Obtain insurance.

(c) Make other arrangements for the cost of providing to an enrollee health services the aggregate value of which is more than $5,000.00 in a year for that enrollee.

(2) If the health maintenance organization requires an affiliated provider to assume financial risk under the terms of its contract, the contract must require both of the following:

(a) The health maintenance organization to pay the affiliated provider, including a subcontracted provider, directly or through a licensed third party administrator for health services provided to its enrollees.

(b) The health maintenance organization to keep all pooled funds and withhold amounts and account for them on its financial books and records and reconcile them at year end pursuant to the contract.

(3) For purposes of this section, a health maintenance organization requires an affiliated provider to assume financial risk if it shares with the affiliated provider, in return for consideration, a portion of the chance of loss, including expenses incurred, related to the delivery of health services to enrollees. The type of transactions under which a health maintenance organization may require an affiliated provider to assume financial risk under this section include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity agreements.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3571 State or federal health programs.

Sec. 3571. A health maintenance organization that participates in a state or federal health program shall meet the solvency and financial requirements of this act, unless the health maintenance organization is in receivership or under supervision. Notwithstanding any provision of this act to the contrary, a health maintenance organization that participates in a state or federal health program is not required to offer benefits or services that exceed the requirements of the applicable program. This section does not apply to state employee or federal employee health programs.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2005, Act 306, Imd. Eff. Dec. 21, 2005;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3573 Operation of health care delivery system not meeting requirements of act; permitted conduct; limitations.

Sec. 3573. (1) A person that proposes to operate a system of health care delivery and financing to be offered to individuals, whether or not as members of groups, in exchange for a fixed payment and to be organized so that providers and the organization are in some part at risk for the cost of services in a manner similar to a health maintenance organization, but that fails to meet the requirements of this act for a health maintenance organization, may operate the system of health care delivery and financing if the director finds that the proposed operation will benefit persons who will be served by it. The director shall authorize and regulate the operation of the system in the same manner as a health maintenance organization under this act, including the filing of periodic reports, except to the extent that the director finds that the regulation is inappropriate to the system of health care delivery and financing.

(2) A person operating a system of health care delivery and financing under this section shall not advertise or solicit or in any way identify itself in a manner implying to the public that it is a health maintenance organization authorized under this act.

History: Add. 2000, Act 252, Imd. Eff. June 29, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

Popular name: HMO

500.3580 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to consumer guide to health maintenance organization.

Popular name: Act 218

Popular name: HMO