ACT 179

H.B. NO. 1918

A Bill for an Act Relating to Health Maintenance Organizations.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER
HEALTH MAINTENANCE ORGANIZATION ACT

§ **-1 Definitions.** For purposes of this chapter:

"Basic health care services" means the following medical services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory services, and diagnostic and therapeutic radiological services. It does not include mental health services, services for alcohol or drug abuse, dental or vision services, or long-term rehabilitation treatment, except as provided in chapter 431M.

"Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value, or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

"Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, a mutual benefit society, or other entity responsible for the payment of benefits or provision of services under a group contract.

"Commissioner" means the insurance commissioner.

"Copayment" means an amount an enrollee must pay to receive a specific service which is not fully prepaid.

"Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

"Enrollee" means an individual who is covered by a health maintenance organization.

"Evidence of coverage" means a statement of the essential features and services of the health maintenance organization coverage that is given to the subscriber by the health maintenance organization or by the group contract holder.

"Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.

"Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

"Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

"Group contract holder" means the person to which a group contract has been issued.

"Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments, deductibles, or both.

"Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

"Insolvent" or "insolvency" means that the health maintenance organization has been declared insolvent and placed under an order of supervision, rehabilitation, or liquidation by a court of competent jurisdiction.

"Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

"Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

"Participating provider" means a provider as defined in this section, who, under an express or implied contract with the health maintenance organization or

with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

"Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.

"Provider" means any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

"Replacement coverage" means the benefits provided by a succeeding carrier.

"Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

"Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency, and for which no alternative arrangements have been made that are acceptable to the commissioner. Uncovered expenditures do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization.

§ **-2 Establishment of health maintenance organizations.** (a) Any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. No person shall establish or operate a health maintenance organization in this State without obtaining a certificate of authority under this chapter. A foreign corporation may qualify under this chapter, subject to its registration to do business in this State in compliance with all provisions of this chapter and other applicable state laws.

(b) Any health maintenance organization which has not previously received a certificate of authority to operate as a health maintenance organization as of the effective date of this chapter shall submit an application for a certificate of authority under subsection (c) within one-hundred-eighty days of the effective date of this chapter. Each applicant may continue to operate until the commissioner acts upon the application. In the event that an application is denied under this chapter, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, official positions, and biographical information on forms acceptable to the commissioner of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, and the principal officers in the case of a corpora-

tion, or the partners or members in the case of a partnership or association;

(4) A copy of any contract form made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third party administrators, marketing consultants, or persons listed in paragraph (3) and the health maintenance organization;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support, and both a copy of the applicant's most recent certified financial statement and an unaudited current financial statement;

(8) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments, deposits with the State, income and expense statements anticipated from the start of operations until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

(9) A power of attorney duly executed by such applicant, if not domiciled in this State, appointing the commissioner and the commissioner's successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;

(10) A statement or map reasonably describing the geographic area or areas to be served;

(11) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection against insolvency requirements in section -8;

(14) A list of the names, addresses, and license numbers of all providers or groups of providers with which the health maintenance organization has agreements; and

(15) Such other information as the commissioner may require.

(d) If the commissioner finds that the applicant has met the requirements for and is fully entitled thereto under the applicable insurance laws, the commissioner shall issue an appropriate certificate of authority to the applicant. If the commissioner does not so find, the commissioner shall deny the applicant the certificate of authority within a reasonable length of time following filing of the application by the applicant. A certificate of authority shall be denied only after the commissioner complies with the requirements of section -14.

(e) The commissioner may adopt rules under chapter 91 for the implementation and administration of this chapter.

§ **-3 Powers of health maintenance organizations.** (a) The powers of a health maintenance organization include the following:

(1) Purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(2) Participate in transactions between affiliated entities, including loans and the transfer of responsibility under all providers, subscribers, and other contracts between affiliates or between the health maintenance organization and its parent;

(3) Furnishing health care services through providers, provider associations, or agents for providers which are under contract with or employed by the health maintenance organization;

(4) Contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;

(5) Contracting with an insurance company licensed in this State, or with a hospital or medical service corporation authorized to do business in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) Offering other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(7) Joint marketing of products with an insurance company licensed in this State or with a hospital or medical service corporation authorized to do business in this State as long as the company that is offering each product is clearly identified; and

(8) Offering a point of service product consisting of:

(A) In-plan covered health care services obtained from providers who are employed by, or otherwise affiliated with the health maintenance organization and emergency services; and

(B) Out-of-plan covered services consisting of non-emergency, self-referred covered health care services obtained from providers who are not otherwise employed by, not under contract with, and not otherwise affiliated with the health maintenance organization, or services obtained from affiliated specialists without a referral; provided the health maintenance organization shall not expend more than ten per cent of its total health care expenditures for out-of-plan covered services.

(b) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in subsection (a)(1), (2), or (4) which may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove such exercise of power only if in the commissioner's opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove the request within thirty days of the filing of the notice, it shall be deemed approved. The commissioner may adopt rules exempting from the filing requirement of this subsection those activities having a minimal effect.

§ -4 **Fiduciary responsibilities.** (a) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of an organization shall be responsible for the funds in a fiduciary relationship to the organization.

(b) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees, officers, directors, and partners in an amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the commissioner.

§ -5 **Annual report.** (a) Every health maintenance organization shall annually, on or before March 1, file a report verified by at least two principal officers with the commissioner covering the preceding calendar year. Such report shall comply with sections 431:3-301 and 431:3-302. The commissioner may prescribe on which forms the reports are to be filed. In addition, the health maintenance organization annually shall file with the commissioner the following by the dates specified:

(1) An audit by a designated independent certified public accountant or accounting firm of the financial statements reporting the financial condition and results of operations of the health maintenance organization on or before June 1, or such later date as the commissioner upon request or for cause may specify. The health maintenance organization, on an annual basis and prior to the commencement of the audit, shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit. The commissioner may disapprove the health maintenance organization's designation within fifteen days of receipt of the health maintenance organization's notice, and the health maintenance organization shall be required to designate another independent certified public accountant or accounting firm.

(2) A list of the providers who have executed a contract that complies with section -8(d) on or before March 1; and

(3) A description of the grievance procedures, the total number of grievances handled through those procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances on or before March 1.

(b) The commissioner may require additional reports as are deemed necessary and appropriate to enable the commissioner to carry out the commissioner's duties under this chapter.

(c) The commissioner may suspend or revoke the certificate of authority of any health maintenance organization who fails to file any of the documents required under subsection (a). In lieu or in addition to the suspension or revocation of the certificate of authority of any health maintenance organization, the commissioner may fine the health maintenance organization not less than $100 and not more than $500 for each day of delinquency.

§ -6 **Information to enrollees or subscribers.** (a) The health maintenance organization shall provide to its subscribers a list of providers and participating providers, upon enrollment and reenrollment.

(b) Every health maintenance organization shall provide to its subscribers notice of any material change in the operation of the organization that will affect them directly within thirty days of the material change.

(c) The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services may be obtained, a description of the internal grievance procedures, and a telephone number for the enrollee to contact the health maintenance organization at no cost to the enrollee.

(d) For the purpose of this section "material change" means any major change in provider or participating provider agreements.

§ -7 **Investments.** All investments permitted under this section or section -3(a)(1) can be considered as admitted assets in determination of net worth; provided that these investments are in compliance with rules adopted by the commissioner. With the exception of investments made in accordance with section -3(a)(1), the funds of a health maintenance organization shall be invested only as permitted by rules adopted by the commissioner pursuant to chapter 91.

§ -8 **Protection against insolvency.** (a) Net worth requirements are as follows:

(1) Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization has an initial net worth of $1,500,000 and shall thereafter maintain the minimum net worth required under paragraph (2).

(2) Except as provided in paragraph (3), every health maintenance organization shall maintain a minimum net worth equal to the greater of:
   (A) $1,500,000;
   (B) Two per cent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first $150,000,000 of premium and one per cent of annual premium on the premium in excess of $150,000,000;
   (C) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or
   (D) An amount equal to the sum of:
      (i) Eight per cent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and
      (ii) Four per cent of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

(3) The following shall apply in determining compliance with the requirements of this subsection:
   (A) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated;
   (B) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses; and
   (C) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(b) Deposit requirements are as follows:

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner or, at the discretion of the

commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a value of not less than $300,000;

(2) A health maintenance organization that is in operation on the effective date of this chapter shall make a deposit equal to $150,000. Within one year after the effective date of this chapter, a health maintenance organization that is in operation on the effective date of this chapter shall make an additional deposit of $150,000 for a total of $300,000;

(3) Deposits shall be an admitted asset of the health maintenance organization in the determination of net worth;

(4) All income from deposits shall be an asset of the health maintenance organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted;

(5) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of article 15 of chapter 431; and

(6) The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the director of finance of this State, or the insurance commissioner, or other official body of the state or jurisdiction of domicile of such health maintenance organization, for the protection of all subscribers and enrollees, wherever located, cash, acceptable securities, or surety, and delivers to the commissioner a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

(c) Every health maintenance organization, when determining liabilities, shall include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of claims. Such liabilities shall be computed in accordance with rules adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

(d) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization. In the event that a contract with a participating provider has not been reduced to writing as required by this subsection or that a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

(e) The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements acceptable to the commissioner to assure that benefits are continued as specified above.

(f) An agreement to provide health care services between a provider and a health maintenance organization shall require that a provider shall give the organization at least sixty days' advance notice in the event of termination.

§ **-9 Uncovered expenditures insolvency deposit.** (a) If, at any time, uncovered expenditures exceed ten per cent of total health care expenditures, a health maintenance organization shall place with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, an uncovered expenditures insolvency deposit consisting of cash or securities that are acceptable to the commissioner. Such deposit shall have, at all times, a fair market value in an amount of one-hundred-twenty per cent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this State, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section is in addition to the deposit required under section -8 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from the deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

(c) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(1) A substitute deposit of cash or securities of equal amount and value is made;

(2) The fair market value exceeds the amount of the required deposit; or

(3) The required deposit under subsection (a) is reduced or eliminated.

Deposits, substitutions, or withdrawals may be made only with the prior written approval of the commissioner.

(d) The deposit required under this section is held in trust and may be used only as provided in this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this State for uncovered expenditures in this State. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution.

Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

(e) The commissioner may prescribe by rule the time, manner, and form for filing claims under subsection (d).

(f) The commissioner may require by rule or order health maintenance organizations to file annual, quarterly, or more frequent reports as the commissioner deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

§ -10 **Enrollment period.** (a) In the event of an insolvency of a health maintenance organization, upon order of the commissioner, all other carriers offered as alternatives to the insolvent health maintenance organization at a group's last regular enrollment period shall offer to those members of the group who enrolled in the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(b) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group's enrollees of the insolvent health maintenance organization, then the commissioner shall equitably allocate the insolvent health maintenance organization's group contracts for such 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 is so allocated shall offer the group 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.

(c) The commissioner also shall allocate equitably the insolvent health maintenance organization's nongroup enrollees who are unable to obtain other coverage among all health maintenance organizations which 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 shall offer such nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with 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 one group for rating and coverage purposes.

§ -11 **Replacement coverage.** (a) For purposes of this chapter, "discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(b) Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract

or policy providing such hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(c) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

§ -12 **Powers of insurers and hospital and medical service corporations.** (a) An insurance company licensed in this State, or a hospital or medical service corporation authorized to do business in this State, either directly or through a subsidiary or affiliate, may organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law to the contrary, any two or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(b) Notwithstanding any contrary provision of laws pertaining to insurance or hospital or medical service corporations, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

§ -13 **Examinations.** (a) The commissioner may examine the affairs of any health maintenance organization or of any providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but shall make such examination not fewer than once every three years.

(b) Every health maintenance organization and provider shall submit its books and records for examination and in every way facilitate the completion of the examination. In the event a health maintenance organization or the provider fails to comply with the directions of the commissioner, the commissioner may examine the affiliates of the health maintenance organization or provider to obtain the information. For the purpose of examinations, the commissioner may administer oaths to, and examine the officers and agents of, the health maintenance organization and the principals of providers concerning their business.

(c) The cost of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner for deposit into the insurance examiners revolving fund.

(d) In lieu of such examination, the commissioner may accept the report of an examination made by the commissioner or director of the department of health of another state.

§ -14 **Suspension, revocation, or denial of certificate of authority.** (a) Any certificate of authority issued under this chapter may be suspended or revoked, and any application for a certificate of authority may be denied, if the commissioner finds that any of the conditions listed below exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under section -2, unless amendments to such submissions have been filed with and approved by the commissioner;

(2) The health maintenance organization does not provide or arrange for basic health care services;

(3) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(4) The health maintenance organization has failed to correct, within the time prescribed by subsection (c), any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

(5) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(6) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(7) The health maintenance organization has otherwise failed substantially to comply with this chapter.

(b) In addition to, or in lieu of, suspension or revocation of a certificate of authority pursuant to this section, the commissioner, after hearing, may levy an administrative fine upon the health maintenance organization in an amount not less than $500 and not more than $50,000 pursuant to section 431:3-221.

(c) The following shall pertain when insufficient net worth is maintained:

(1) Whenever the commissioner finds that the net worth maintained by any health maintenance organization subject to this chapter is less than the minimum net worth required, the commissioner shall give written notice to the health maintenance organization of the amount of the deficiency and require the health maintenance organization to:

(A) File with the commissioner a plan for correction of the deficiency acceptable to the commissioner; and

(B) Correct the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted by the commissioner. Such a deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation, or liquidation; and

(2) Unless allowed by the commissioner, no health maintenance organization or person acting on its behalf, directly or indirectly, may renew, issue, or deliver any certificate, agreement, or contract of coverage in this State, for which a premium is charged or collected, when the health maintenance organization writing such coverage is impaired, and the fact of such impairment is known to the health maintenance organization or to such person. However, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement, or

contract when the enrollee exercises an option granted under the plan to obtain a new, renewed, or converted coverage.

(d) A certificate of authority shall be suspended or revoked or an application for a certificate of authority denied, or an administrative penalty imposed, only after compliance with the requirements of this section.

(1) Suspension or revocation of a certificate of authority, denial of an application, or imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct on which suspension, revocation, denial, or administrative penalty is based. The health maintenance organization or applicant, in writing, may request a hearing pursuant to section 431:2-308; and

(2) If the health maintenance organization or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the director of labor and industrial relations stating:

(A) A specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and

(B) A specific place for the hearing.

(e) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(f) When the certificate of authority of a health maintenance organization is revoked, such organization, immediately following the effective date of the order of revocation, shall proceed to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner, by written order, may permit such further operation of the organization as the commissioner may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

§ -15 Rehabilitation, liquidation, or conservation of health maintenance organizations. (a) Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in article 15 of chapter 431, or when in the commissioner's opinion, the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the general public. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(b) For purpose of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by article 15 of chapter 431, for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the

status of an enrollee claim for distribution of general assets. Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in article 15 of chapter 431.

§ **-16 Summary orders and supervision.** (a) Whenever the commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this chapter, the commissioner, after notice and hearing, may order the health maintenance organization to take such action as may be reasonably necessary to rectify such condition or violation, including but not limited to one or more of the following:

(1) Reducing the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;
(2) Reducing the volume of new business being accepted;
(3) Reducing expenses by specified methods;
(4) Suspending or limiting the writing of new business for a period of time;
(5) Increasing the health maintenance organization's capital and surplus by contribution; or
(6) Taking such other steps as the commissioner may deem appropriate under the circumstances.

(b) For purposes of this section, the violation by a health maintenance organization of any law of this State to which such health maintenance organization is subject shall be deemed a violation of this chapter.

(c) The commissioner is authorized, by rule, to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in subsection (a).

(d) The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of article 15 of chapter 431.

§ **-17 Fees.** (a) The commissioner shall collect in advance the following fees:

(1) For filing an application for a certificate of authority or amendment thereto, $600; and
(2) For all services subsequent to the issuance of a certificate of authority (including extension of the certificate of authority), $400.

(b) All fees collected pursuant to this section and penalties collected pursuant to section -14 shall be remitted by the commissioner to the director of finance and shall be placed to the credit of the general fund.

§ **-18 Penalties and enforcement.** (a) The commissioner, in lieu of suspension or revocation of a certificate of authority, may impose an administrative fine pursuant to section -14(b).

(b) If the commissioner, for any reason, has cause to believe that any violation of this chapter has occurred or is threatened, the commissioner may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the

purpose of attempting to ascertain the facts relating to such suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation. Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no order may result from a conference until the requirements of this section are satisfied.

(c) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter. Any person aggrieved by an order of the commissioner under this section may obtain judicial review of the order in the manner provided for by chapter 91.

(d) In the case of any violation of the provisions of this chapter, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (c), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in any court of competent jurisdiction.

(e) Notwithstanding any other provisions of this chapter, if a health maintenance organization fails to comply with the net worth requirement of this chapter, the commissioner may take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

§ **-19 Statutory construction and relationship to other laws.** (a) Except as otherwise provided in this chapter, the insurance laws and hospital or medical service corporation laws shall not apply to the activities authorized and regulated under this chapter of any health maintenance organization granted a certificate of authority under this chapter. This chapter shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization granted a certificate of authority under this chapter shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter 453 relating to the practice of medicine or chapter 460 relating to the practice of osteopathic medicine.

§ **-20 Filings and reports as public documents.** Notwithstanding chapter 92F and any other laws to the contrary, all applications and filings required under this chapter shall be treated as public, except for trade secrets or privileged or confidential quality assurance, commercial, or financial information; provided that any annual financial statement that may be required under section -5 shall be public.

§ **-21 Confidentiality of medical information.** Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, upon the express consent of the enrollee or applicant, pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of a claim or

litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

§ **-22 Acquisition of control of or merger of a health maintenance organization.** No person may make a tender for or a request or invitation for tenders of, enter into an agreement to exchange securities for, or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the health maintenance organization, information required by section 431:11-103(a)(1), (2), (3), (4), (5), and (12) and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner. Approval by the commissioner shall be governed by section 431:11-104(d).

§ **-23 Required provisions and benefits.** Notwithstanding any provision of law to the contrary, each policy, contract, plan, or agreement issued in the State after January 1, 1995, by health maintenance organizations pursuant to this chapter, shall include benefits provided in sections 431:10-212, 431:10A-115, 431:10A-115.5, 431:10A-116, 431:10A-116.5, and 431:10A-116.6 and chapter 431M.

§ **-24 Coordination of benefits.** (a) Health maintenance organizations are permitted, but not required to adopt provisions for coordination of benefits to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.

(b) If health maintenance organizations adopt provisions for coordination of benefits, the provisions must be consistent with the coordination of benefits provisions that are in general use in the State for coordinating coverage between two or more group health insurance or health care plans."

SECTION 2. If any provision of this Act, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 3. This Act shall take effect on January 1, 1996.

(Approved June 14, 1995.)