

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

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Section 1. Short Title

This Act may be cited as the Health Maintenance Organization Act of [insert year].

Section 2. Purpose and Intent

The purpose of this Act is to provide for a system of regulation for health maintenance organizations that is fair and efficient, and promotes the continued solvency of health maintenance organizations. This Act is designed to operate in conjunction with and as a companion to other state laws that establish standards for the regulation of health maintenance organizations, such as [insert state law equivalent to the Managed Care Plan Network Adequacy Model Act, the Quality Assessment and Improvement Model Act, the Health Care Professional Credentialing Verification Model Act, the Utilization Review Model Act, the Health Carrier Grievance Procedure Model Act, the Health Carrier External Review Model Act, the Health Information Privacy Model Act, the Unfair Trade Practices Model Act, the Unfair Claims Settlement Practices Model Act, the Insurance Holding Company System Regulatory Act and the Risk-Based Capital (RBC) for Health Organizations Model Act].

Drafting Note: This model act presumes the existence of state laws that are based on the listed NAIC model acts described in this section. States that have not already adopted these laws should consider adopting them to ensure that a comprehensive system of regulation for health maintenance organizations is in place.

Section 3. Definitions

- A. “Adverse determination” means a determination by a health maintenance organization or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health maintenance organization’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.
- B. “Basic health care services” includes the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services. It does not include mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment.
- C. “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.
- D. “Coinsurance” means the percentage amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.

Drafting Note: States that do not allow HMOs to impose a coinsurance requirement should not adopt this definition nor include the term when it is referenced throughout the model.

- E. “Commissioner” means the insurance commissioner of this state.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of health maintenance organizations lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- F. “Copayment” means a specified dollar amount a covered person must pay under the terms of a health benefit plan in order to receive a health care service that is not fully prepaid.
- G. “Covered benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- H. “Covered person” means any person eligible to receive covered benefits under the terms of a health benefit plan.
- I. “Deductible” means the amount a covered person is responsible to pay out-of-pocket before the health maintenance organization begins to pay the covered expenses associated with treatment.
- J. “Enrollee” 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.
- K. “Evidence of coverage” means a statement that sets out the coverage and other rights to which the covered person is entitled under the health benefit plan and that may be issued by the health maintenance organization or by the group contract holder to an enrollee electronically or, upon request, in writing.
- L. “Extension of benefits” means the continuation of coverage under a particular benefit provided under a contract following termination with respect to a covered person who is totally disabled on the date of termination.

- M. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- N. “Grievance” means a written complaint submitted by or on behalf of a covered person regarding:
- (1) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
 - (2) Claims payment, handling or reimbursement for health care services; or
 - (3) Matters pertaining to the contractual relationship between a covered person and a health maintenance organization.
- O. “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.
- P. “Group contract holder” means a person, other than an individual, to which a group contract has been issued.
- Q. “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- R. “Health care professional” means a physician or other health care practitioner license, accredited or certified to perform specified health services consistent with state law.
- S. “Health care provider” or “provider” means a health care professional or facility.
- T. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- U. “Health carrier” or “carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, managed care organization, health maintenance organization, a nonprofit hospital or medical service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

Drafting Note: The term “hospital or medical service corporation,” as used in the model act, is intended to apply to any nonprofit health, hospital or medical service corporation or similar organization. In order to include such organizations in this section, which are also commonly referred to as “Blue Cross Blue Shield-type” plans, each state should identify these organizations in accordance with its statutory terminology for such plans or by specific statutory citation. Some states also may have to amend other laws to bring these organizations within the scope of this section since the portions of state law applicable to these organizations may provide that no other portion of the insurance code applies to these organizations without a specific reference to the other provision.

- V. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for a covered person’s responsibility for copayments, coinsurance or deductibles.
- W. “Individual contract” means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the enrollee.
- X. “Insolvent” or “insolvency” shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.
- Y. “Intermediary organization” means a person, other than an individual, authorized to negotiate and execute provider contracts with health maintenance organizations on behalf of a group of health care providers or on behalf of a network, but does not include a provider or group of providers negotiating on its own behalf.

- Z. “Network” means the group of participating providers providing services to a health maintenance organization.
- AA. “Net worth” means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.
- BB. “Participating provider” means a provider that, 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 covered persons with an expectation of receiving payment, other than copayments, coinsurance or deductibles, from the health maintenance organization or other organization under contract with the health maintenance organization to provide payment in accordance with the terms of the contract.
- CC. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or a combination of the foregoing.
- DD. “Policyholder” means, for individual contracts, the individual in whose name the contract is issued, and for group contracts, the group contract holder.
- EE. “Qualified actuary” means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the commissioner may require.
- FF. “Replacement coverage” means the benefits provided by a succeeding carrier.
- GG. “Risk bearing entity” means an intermediary organization that is at financial risk for services provided through contractual assumption of the obligation for the delivery of specified health care services to covered persons of the health maintenance organization.
- HH. “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 a covered person 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.

Drafting Note: Subsection HH defines uncovered expenditures for use in Section 20. They will vary in type and amount, depending on the arrangements of the health maintenance organization. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the covered person 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.

- II. “Utilization review” means a set of formal techniques utilized by or on behalf of the health maintenance organization designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

Section 4. Applicability and Scope

This Act applies to all health maintenance organizations and risk bearing entities doing business in this state.

Section 5. Establishment of Health Maintenance Organizations

Option A:

- A. Notwithstanding any law of this state to the contrary, any person other than an individual may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this Act. A foreign corporation may qualify under this Act, subject to its registration to do business in this state as a foreign corporation under [insert reference to applicable state law] and compliance with all provisions of this Act and other applicable state laws.

Drafting Note: State laws differ as to whether a health maintenance organization is required to be a domestic corporation. This provision should be adopted if your state wants to permit a foreign corporation to qualify under this Act if it registers to do business in a state as a foreign corporation and complies with all provisions of this Act and other applicable state laws.

Option B:

- A. Notwithstanding any law of this state to the contrary, any organization may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this Act. A person shall not establish or operate a health maintenance organization in this state without obtaining a certificate of authority under this Act.

Drafting Note: State laws differ as to whether a health maintenance organization may be a foreign corporation. This option does not differentiate between foreign and domestic corporations. Whether or not to allow foreign corporations to become health maintenance organizations should be determined in light of a particular state's regulatory framework.

- B. 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 demonstrate, 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) A disclosure of the internal organizational structure identifying senior management employees;
 - (b) A disclosure of the external organizational structure identifying all parent, subsidiary and affiliate organizations; and
 - (c) If the applicant is a member of a holding company:
 - (i) Identification of the holding company; and
 - (ii) A copy of the most recent holding company Form B that includes current financial information for the ultimate controlling party;
 - (4) The applicant's federal identification number, NAIC number if applicable, corporate address and mailing address;
 - (5)
 - (a) The names, addresses, official positions and biographical affidavit of the individuals who are to be responsible for the conduct of the affairs of the applicant, including, but not limited to all members of the board of directors, executive committee, and the principal officers accompanied by a completed release of information for each of these individuals, on forms acceptable to the commissioner; and
 - (b) A disclosure of any person owning or having the right to acquire five percent (5%) or more of the voting securities or subordinated debt of the applicant;
 - (6) A detailed plan of operation for [insert state name];
 - (7) A description of the applicant and its personnel, and, where applicable, its facilities, including, but not limited to, location, hours of operation and telephone numbers;

- (8) A copy of:
 - (a) Any contract made or to be made between the applicant and an affiliated or unaffiliated person for managerial or administrative services, including, third party administrators, marketing consultants or persons listed in Paragraph (5); and
 - (b) Sample contract forms proposed for use between the applicant and persons providing health care services to covered persons, including, participating providers and intermediary organizations.

Drafting Note: Section 8A of the Managed Care Plan Network Adequacy Model Act requires the filing of substantially similar information to the filing of sample provider contracts required in Paragraph (8)(b). States that have adopted the Managed Care Plan Network Adequacy Model Act should consider whether it is necessary to include a similar requirement in this Act as well.

- (9) A copy of each type of evidence of coverage and identification card or similar document to be issued to the enrollees;
- (10) A copy of each type of individual or group policy, contract or agreement to be used;
- (11) A copy of all marketing materials;
- (12) A copy, if applicable, of the most recent financial examination report made of the health maintenance organization within the previous three (3) years, certified by the insurance regulatory agency of the applicant's state of domicile;
- (13)
 - (a) A copy of the applicant's financial statements showing the applicant's assets, liabilities and sources of financial support, including a copy of the applicant's most recent audited financial statement that complies with [insert reference to state law equivalent to Model Regulation Requiring Annual Audited Financial Reports] and an unaudited current financial statement; or
 - (b) If the information in Subparagraph (a) of this paragraph is not applicable to the applicant, a list of the assets representing the initial net worth of the applicant;

Drafting Note: States should ensure that the state law equivalent to the Model Regulation Requiring Annual Audited Financial Reports is applicable to health maintenance organizations before referencing it in Paragraph (13)(a).

- (14) A financial plan that provides a three-year projection of operating results, including:
 - (a) A projection of balance sheets;
 - (b) Income and expense statements anticipated from the start of operations until the organization has had net income for at least one year;
 - (c) Cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state;
 - (d) Detailed enrollment projections;
 - (e) The methodology for determining premium rates to be charged that has been certified by a qualified actuary; ; and
 - (f) A statement as to the sources of working capital as well as any other sources of funding;
- (15) The names and addresses of the applicant's qualified actuary and external auditors;

- (16) If the applicant has a parent company and the commissioner determines that additional solvency guarantees are necessary, the parent company's guaranty, on a form acceptable to the commissioner, that the applicant will maintain the minimum net worth required under this Act. If no parent company exists, a statement regarding the availability of future funds if needed;
- (17) A description of the nature and extent of any reinsurance program to be implemented, including a detailed risk retention schedule indicating direct, assumed, ceded and net maximum risk exposures on any one risk;
- (18) A demonstration that errors and omission insurance or other arrangements satisfactory to the commissioner will be in place upon the applicant's receipt of a certificate of authority;
- (19) Information regarding the proposed fidelity bond required pursuant to Section 24B of this Act;
- (20) If the applicant is a foreign corporation, a statement from the appropriate regulatory agency of the applicant's state of domicile stating that:
 - (a) The applicant is authorized to operate as a health maintenance organization in the state of domicile;
 - (b) The regulatory agency has no objection to the applicant applying for a certificate of authority in this state; and
 - (c) The applicant is in good standing in the applicant's state of domicile;
- (21) The name and address of the applicant's [insert state name] statutory agent for service of process, notice, or demand, or if not domiciled in this state, a power of attorney duly executed by the applicant, appointing the commissioner and duly authorized deputies, as the true and lawful attorney of the 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;
- (22) A description of the proposed policies, standards and procedures for the management of health information, including proposed policies, standards and procedures that guard against the unauthorized collection, use or disclosure of protected health information, that complies with [insert reference to state law equivalent to the Health Information Privacy Model Act];
- (23) A description of the proposed quality assessment and improvement activities that comply with [insert reference to state law equivalent to the Quality Assessment and Improvement Model Act] regarding the maintenance and improvement of the quality of health care services provided to covered persons;
- (24) If the health maintenance organization will not operate statewide, a statement or map describing the service area;
- (25) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements;
- (26) A description of the proposed network adequacy standards that assure the adequacy, accessibility and quality of health care that complies with [insert reference to state law equivalent to the Managed Care Plan Network Adequacy Model Act];
- (27) A description of the proposed health care provider credentialing program in compliance with [insert reference to state law equivalent to the Health Care Professional Credentialing Verification Model Act];

- (28) If the health maintenance organization will provide or perform utilization review services, a description of the proposed utilization review procedures that comply with [insert reference to state law equivalent to the Utilization Review Model Act] regarding the ongoing assessment and management of health care services;
- (29) A description of the proposed internal grievance procedures that comply with [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act] regarding the investigation and resolution of covered persons' complaints and grievances;
- (30) A description of the proposed external review procedures that comply with [insert reference to state law equivalent to the Health Carrier External Review Model Act] regarding the external independent review of covered persons' grievances; and
- (31) Any other information the commissioner may require.

Section 6. Issuance or Denial of Certificate of Authority

- A. Within ninety (90) days of receipt of a completed application, the commissioner shall issue a certificate of authority when the commissioner is satisfied that:
 - (1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;
 - (2) The name of the health maintenance organization is not the same as, or deceptively similar to, the name of a domestic insurer, or of a foreign or alien company authorized to transact business in this state, nor does the name of the health maintenance organization tend to deceive or mislead as to the authorization of the health maintenance organization to engage in a specific line of business;
 - (3) The health maintenance organization will provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments, coinsurance or deductibles; and
 - (4) The health maintenance organization is in compliance with the requirements of this Act.
- B. A certificate of authority shall be denied only after the commissioner complies with the requirements of Section 29 of this Act.

Section 7. Powers of Health Maintenance Organizations

- A. The powers of a health maintenance organization include, but are not limited to, the following:
 - (1) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and property reasonably required for its principal office or for purposes necessary to the transaction of the business of the organization;
 - (2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts (provider, subscriber, etc.) between affiliates or between the health maintenance organization and its parent;
 - (3) The furnishing of health care services through providers, provider associations, intermediary organizations or agents for providers which are under contract with or employed by the health maintenance organization;
 - (4) The contracting with a person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

- (5) The 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) The offering of 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) The 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.

Drafting Note: States that allow health maintenance organizations to offer a point of services contract may wish to consider additional requirements for those organizations, including but not limited to, additional ongoing net worth and capital, additional deposits, more detailed annual and quarterly financial statement filings, limitations on out-of-plan expenditures and additional reinsurance coverage.

- B. (1) 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) that may affect the financial soundness of the health maintenance organization. The commissioner shall disapprove the 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 within thirty (30) days of the filing, it shall be deemed approved.
- (2) The commissioner may promulgate rules and regulations exempting from the filing requirement of Paragraph (1) those activities having a *de minimis* effect.
- (3) Transactions between affiliated entities shall be subject to [insert reference to state law equivalent to NAIC Insurance Holding Company System Regulatory Act].

Section 8. Contract Requirements

- A. Each group or individual contract holder is entitled to a group or individual contract within thirty (30) days of the effective date of a new or amended contract.
- B. The contract shall not contain provisions or statements that:
 - (1) Are unjust, unfair, inequitable, misleading, or deceptive; or
 - (2) Encourage misrepresentation as defined by [reference to state law equivalent to the NAIC Unfair Trade Practices Act].
- C. (1) The contract shall contain a clear statement of the following:
 - (a) Name and address of the health maintenance organization;
 - (b) Eligibility requirements;
 - (c) Benefits and services within the service area;
 - (d) Emergency care benefits and services;
 - (e) Out of area benefits and services (if any);
 - (f) Copayments, coinsurance, deductibles or other out-of-pocket expenses, the financial responsibility of the covered person and how the covered person's obligation is determined;

- (g) Provider hold harmless provisions;
 - (h) Limitations and exclusions;
 - (i) covered person termination;
 - (j) covered person reinstatement (if any);
 - (k) Claims procedures;
 - (l) Utilization review procedures;
 - (m) Grievance procedures;
 - (n) Procedures for requesting independent external review;
 - (o) Continuation of coverage;
 - (p) Conversion;
 - (q) Extension of benefits (if any);
 - (r) Coordination of benefits (if applicable);
 - (s) Subrogation (if any);
 - (t) Description of the service area;
 - (u) Procedures for obtaining a provider directory;
 - (v) The existence of a formulary and procedures for obtaining a copy of the formulary list (if applicable);
 - (w) Entire contract provision;
 - (x) Term of coverage;
 - (y) Cancellation of group or individual contract holder;
 - (z) Renewal;
 - (aa) Reinstatement of group or individual contract holder (if any);
 - (bb) Grace period; and
 - (cc) Conformity with state law.
- (2) An evidence of coverage may be filed as part of the group contract to describe the provisions required in Paragraph (1).
- D. (1) In addition to the provisions required in Subsection C(1), an individual contract shall provide for a ten-day period to examine and return the contract and have the premium refunded.
- (2) If services were received during the ten-day period, and the individual returns the contract to receive a refund of the premium paid, the individual must pay for those services.
- E. The commissioner may adopt regulations establishing readability standards for individual and group contract forms.

Drafting Note: The commissioner may adopt standards in the NAIC Life and Health Insurance Policy Language Simplification Act.

Section 9. Risk Bearing Entity Registration and Contracting Requirements

A. Registration Requirements.

- (1) All risk bearing entities shall register annually with the commissioner in this state unless already subject to state insurance regulation.

Drafting Note: A state may wish to exempt a risk bearing entity from the registration requirements of this subsection, or modify the provisions of this subsection as they apply to a risk bearing entity, where a risk bearing entity accepts risk exclusively from a single health maintenance organization, provides direct care to covered persons of that health maintenance organization, and where detail of claims payments is available for examination from the health maintenance organization. A state may want to require the health maintenance organization to demonstrate to the commissioner that the contractual arrangement with the risk bearing entity will allow it to fulfill the provisions of its contract for the contract year. Health maintenance organizations contracting with risk bearing entities that are exempt from this subsection, or subject to modified registration requirements, should be subject to Subsections C and D of this section and Section 19 of this Act.

- (2) The registration shall be in a form approved by the commissioner and shall include:
 - (a) The name of the risk bearing entity;
 - (b) The business address of the risk bearing entity;
 - (c) The principal contact person for risk bearing entity;
 - (d) The names and positions of senior officers of risk bearing entity, including, President, Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Executive Vice Presidents, Treasurer and Secretary;
 - (e) A list of all entities on whose behalf the risk bearing entity has contracts or agreements to provide health care services;
 - (f) A matrix listing of all major categories of health care services provided by the risk bearing entity;
 - (g) An approximate number of total covered persons served in all the risk bearing entity's contracts or agreements;
 - (h) An annual audited Generally Accepted Accounting Principles (GAAP) financial statement;
 - (i) A list of all subcontractors of the risk bearing entity;
 - (j) Sample contract forms proposed for use between subcontractors and the risk bearing entity;
 - (k) A list of all stop loss arrangements; and
 - (l) Any other information or financial information requested by the commissioner.
- (3) The commissioner may charge a registration fee sufficient to cover the cost of implementing this section.
- (4) The risk bearing entity shall permit the commissioner to:
 - (a) Inspect the risk bearing entity's books and records; and
 - (b) Examine, under oath, any officer or agent of the risk bearing entity with respect to the use of its funds and compliance with the terms and conditions of its contracts to provide covered benefits under the health benefit plan.

- (5) A risk bearing entity shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this section, together with such supporting documents as are necessary to explain the modification.

B. Contracting Requirements

- (1) Except as provided in Paragraph (2), a health maintenance organization shall not contract with a risk bearing entity that has not registered in accordance with this section.
- (2) The requirements of this section shall apply to any contract entered into, amended or renewed after the effective date of this section and shall apply to all contracts no later than two (2) years after the effective date of this section.
- (3) A health maintenance organization shall:
 - (a) Unless already specified in the contract with the risk bearing entity, provide the following, upon request, to the risk bearing entity with which it contracts:
 - (i) At the time the contract is entered into, a written statement describing the amount or method of remuneration to be paid to the risk bearing entity. If any part of the remuneration is a calculated amount based on variable factors, the payment methodology upon which the calculated amount will be determined. The statement shall specify the services and expenses for which the risk bearing entity is financially liable in whole or part;
 - (ii) At the time payment is made, the basis of the calculation of that payment;
 - (iii) For health benefit plans in which the covered persons are assigned to the risk bearing entity under a capitated payment arrangement, a list of enrollees and payments due to the risk bearing entity, to be provided monthly if not already available to the risk bearing entity;
 - (iv) At the time the contract is entered into, a copy of the health maintenance organization's most recent annual statement filed with the NAIC;
 - (v) Once the contract is in effect, the quarterly or annual statement filed with the NAIC; and
 - (vi) Any other information requested by the commissioner.
 - (b) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization at the time a contract is entered into and annually thereafter:
 - (i) Annual audited GAAP report;
 - (ii) Documentation that satisfies the health maintenance organization that the risk bearing entity has sufficient ability to accept risk; and
 - (iii) Documentation that satisfies the health maintenance organization that the risk bearing entity has appropriate management expertise and infrastructure;
 - (c) Include in its contracts with a risk bearing entity a provision that requires the risk bearing entity to provide to the health maintenance organization a quarterly status report that includes:
 - (i) GAAP financial statements;

- (ii) An aging report of the percentage of claims that have been paid, pending or denied, across all contracts with risk bearing entities; and
 - (iii) On a monthly basis, a report of the estimated reported claims and incurred but not reported claims liability of the risk bearing entity; and
- (d) Require that a risk bearing entity with which the health maintenance organization contracts provide notice within thirty (30) days to the health maintenance organization of:
 - (i) Any changes involving the ownership structure of the risk bearing entity;
 - (ii) Financial or operational concerns regarding the financial viability of the risk bearing entity; or
 - (iii) Loss of registration.
- (4) A health maintenance organization shall provide to the commissioner on a quarterly basis a list of all risk bearing entities with which it has an agreement or contract and the number of covered persons assigned or selected by each risk bearing entity, and any additional information the commissioner may require.
- (5) A health maintenance organization shall include in its contracts with a risk bearing entity a provision that allows the commissioner, in the event that a risk bearing entity fails to comply with any provision of this Act, to assign for six (6) months, the risk bearing entity's contract with providers to furnish covered services.

C. Oversight Responsibility

- (1) A health maintenance organization shall have procedures in place to notify the commissioner within a reasonable time that a risk bearing entity has materially failed to perform under its contract with the health maintenance organization. A health maintenance organization is not in violation of this paragraph if it acts in good faith in its attempt to comply. The commissioner may by rule enumerate more specific circumstances under which a report may be filed.
- (2) A health maintenance organization shall maintain systems and controls for, including but not limited to, reviewing the information provided to the health maintenance organization by the risk bearing entity pursuant to this Act.
- (3) Any information that has been provided to the commissioner by a health maintenance organization pursuant to this subsection is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act and as allowed by state law, regardless of whether the information is in the form of paper, is preserved on microfilm or is stored in computer readable form. If the information is disclosed pursuant to this subsection, the health maintenance organization providing the notice shall not be liable for the disclosure or any subsequent use or misuse of the information. The health maintenance organization shall be entitled to claim any statutory privileges against disclosure that the entity that provided the information to the health maintenance organization is entitled to claim.
- (4) Any person acting as a director, officer, employee, contractor or agent of a health maintenance organization, who, in good faith and without malice, makes any decision or takes any action to provide a notice of the type contemplated by this subsection shall not be subject to liability for civil damages or any legal action in consequence of that decision or action, nor shall the health maintenance organization, or any other director, officer, employee, contractor or agent be liable for the activities of the person.

- (5) In the event that a health maintenance organization has been notified that the registration of a risk bearing entity has been terminated, revoked, non-renewed or forfeited for any reason, a health maintenance organization shall terminate its contract with the risk bearing entity unless specific permission is provided by the commissioner to maintain the contract at the request of both parties, or enter into an agreement pursuant to which the risk bearing entity ceases to bear risk. The commissioner may set conditions on any agreements between the risk bearing entity and the health maintenance organization.
- (6) This subsection is not intended to create a private right of action.

D. Continuity of Care.

Notwithstanding any agreement to the contrary, the health maintenance organization shall:

- (1) Retain full responsibility on a prospective basis for the provision of health care services pursuant to any applicable health benefit plan; and
- (2) At all times, be able to demonstrate to the satisfaction of the commissioner that the health maintenance organization can fulfill its non-transferable obligation to provide health care services to covered persons in any event, including the failure, for any reason, of a risk bearing entity.

E. Enforcement Against Risk Bearing Entities.

- (1) If the commissioner determines that a risk bearing entity has not complied with any provision of this Act, the commissioner may terminate the risk bearing entity's registration, institute a corrective action against the risk bearing entity, or use any of the commissioner's other enforcement powers to obtain compliance with this Act.
- (2) The commissioner shall, within five (5) business days, inform each health maintenance organization with which a risk bearing entity contracts, in writing:
 - (a) Of any corrective action undertaken by the commissioner against a risk bearing entity; and
 - (b) If the registration of a risk bearing entity has been revoked, non-renewed, forfeited or terminated.
- (3) The commissioner may, in the event that a risk bearing entity fails to comply with any provision of this Act, require the assignment of the risk bearing entity's contract to furnish covered services for a period not to exceed six (6) months.
- (4) The commissioner may assess fines on a risk bearing entity for every day that the entity has failed to meet the registration requirements of this section.

Section 10. Form and Rate Filing Requirements

Drafting Note: States that require prior approval of policy forms and premium rates should adopt Option A. States that have a system of file and use for policy forms and premium rates should adopt Option B.

Option A. Prior Approval

- A. Subject to Subsections B and C, no group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed with and approved by the commissioner.

- B. (1) Every form required by this section shall be filed with the commissioner not less than thirty (30) days prior to delivery or issue for delivery in this state. At any time during the initial thirty-day period, the commissioner may extend the period for review for an additional thirty (30) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the commissioner has taken no action. The filer must notify the commissioner in writing prior to using a form that is deemed approved.
- (2) At any time, after thirty (30) days notice and for cause shown, the commissioner may withdraw approval of a form, effective at the end of the thirty-day period.
- (3) Whenever the commissioner disapproves a form or withdraws approval of a form, the commissioner shall notify the health maintenance organization in writing of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing.
- C. (1) A health maintenance organization shall not use a premium rate until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.
- (2) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.
- (3) Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

- (4) The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of Paragraph (2) are met. If the commissioner disapproves the filing, the commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. If the commissioner does not take action on the schedule or methodology within thirty (30) days of the date of the filing of the schedule or methodology, it shall be deemed approved.

- D. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a form or rate filing made pursuant to this section.

Option B. File and Use

- A. No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form and rates have been filed with the commissioner at least thirty (30) days prior to its issuance or delivery.

- B. (1) At any time, after its issuance and delivery, and for cause shown, the commissioner may disapprove the use of a form. The disapproval shall be effective thirty (30) days after the health maintenance organization receives the notice described in Paragraph (2).
- (2) The commissioner shall notify the health maintenance organization, in writing, of the reasons for disapproval of the form. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for hearing shall stay the effect of the disapproval.
- C. (1) A health maintenance organization shall not use a premium rate unless the premium rate or a methodology for determining the premium rate has been filed with the commissioner at least thirty (30) days prior to its use.
- (2) The health maintenance organization shall certify that the rates meet the requirements of Paragraph (4).
- (3) Any schedule of premium rates or rating methodology submitted pursuant to this subsection shall clearly state any copayments, coinsurance or deductibles to be paid by the covered person.
- (4) A specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of covered persons, provided that the premium applicable to a covered person shall not be individually determined based on the status of the covered person's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A qualified actuary or other qualified person acceptable to the commissioner must certify the appropriateness of the use of the methodology, based on reasonable assumptions, backed by adequate supporting information.

Drafting Note: States may wish to vary the type of information required to accompany a rate filing based on the type of rating mechanism in use. For instance, requiring that only the rating methodology for setting premium rates accompany the rate filing may be sufficient for experience rated groups, while requiring the rate filing to include both the schedule of rates and the rating methodology used to set the rates may be more appropriate for community rated or pooled groups. Regardless of whether a rating methodology or schedule of rates is required to accompany the rate filing, states should require that adequate supporting documentation be included.

- (5) At any time after its implementation, and for good cause shown, the commissioner may disapprove the use of a specific rate or rating methodology. The commissioner shall notify the health maintenance organization, in writing, of the reasons for the disapproval. The notice shall inform the health maintenance organization that the health maintenance organization has thirty (30) days after the date it receives the notice, to make a written request for a hearing. The commissioner shall conduct a hearing within thirty (30) days after the date the commissioner receives the written request for a hearing. A written request for a hearing shall stay the effect of the disapproval.

Section 11. Evidence of Coverage

- A. (1) Every enrollee shall receive an evidence of coverage from the group contract holder or the health maintenance organization.
- (2) The evidence of coverage shall not contain provisions or statements that are unfair, unjust, inequitable, misleading, deceptive, or that encourage misrepresentation as defined by [insert reference to state law equivalent to the NAIC Unfair Trade Practices Act].
- (3) The evidence of coverage shall contain a clear statement of the provisions required in Section 8C of this Act.
- B. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner of this state for approval.

Section 12. Marketing and Advertising Materials

- A. The advertising and marketing materials of health maintenance organizations are subject to the requirements of [insert reference to state law equivalent to the NAIC Advertisements of Accident and Sickness Insurance Model Regulation].
- B. The advertising and marketing materials of health maintenance organizations marketing Medicare supplement insurance are subject to the requirements of [insert reference to state law equivalent to the NAIC Medicare Supplement Insurance Minimum Standards Model Act and the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act].
- C. The advertising and marketing materials of health maintenance organizations marketing long-term care insurance are subject to the requirements of [insert reference to state law equivalent to the NAIC Long-Term Care Insurance Model Regulation].

Section 13. Information to Enrollees and Covered Persons

- A. A health maintenance organization shall provide, within thirty (30) days, notice to enrollees of any material change in the operation of the organization that will affect them directly.
- B.
 - (1) The health maintenance organization shall make written copies of provider directories available to enrollees upon enrollment and re-enrollment.
 - (2) The health maintenance organization shall provide written copies of provider directories to covered persons upon request.
 - (3) The health maintenance organization shall provide the directory and any updates to enrollees, in writing or by electronic means, in accordance with the terms of its contract.
- C.
 - (1) A health maintenance organization shall notify covered persons of the termination of the primary care provider who currently provides health care services to that covered person.
 - (2) A health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to receive notice in writing or by electronic means, of the termination of the primary care provider who currently provides health care services to that covered person.
 - (3) The health maintenance organization shall provide assistance to the covered person in transferring to another participating primary care provider.
- D. The health maintenance organization shall establish a method to permit a covered person, at the option of the covered person, to obtain information in writing or by electronic means, on how services may be obtained, where additional information on access to services may be obtained and a telephone number where covered persons may contact the health maintenance organization, at no cost to the covered person.

Drafting Note: For the purpose of this section any major change in the provider network is considered a material change.

Section 14. Continuation of Benefits

- A. The commissioner shall require that each health maintenance organization have a plan for handling insolvency that provides for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to covered persons who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.
- B. 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, after the health maintenance organization's insolvency, to provide covered services through the period for which premium has been paid to the health maintenance organization on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency will continue until their confinement in an inpatient facility is no longer medically necessary;
- (3) Insolvency reserves;
- (4) Acceptable letters of credit; or
- (5) Any other arrangements to assure that benefits are continued as specified above.

Section 15. Coordination of Benefits

- A. Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health benefit plans.
- B. If a health maintenance organization adopts coordination of benefits provisions, the provisions shall be consistent with [insert reference to state law equivalent to NAIC Group Coordination of Benefits Model Regulation] in general use in the state for coordinating coverage between two (2) or more group health insurance or health benefit plans.
- C. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination consistent with [insert reference to state law equivalent to NAIC Group Coordination of Benefits Model Regulation], health maintenance organizations shall make payments for services that are:
 - (1) Received from non-participating providers;
 - (2) Provided outside their service areas; or
 - (3) Not covered under the terms of their group contracts or evidence of coverage.

Section 16. Initial Net Worth and Capital Requirements

- A. Before the commissioner issues a certificate of authority in accordance with Section 6 of this Act, an applicant seeking to establish or operate a health maintenance organization shall have the greater of:
 - (1) The amount of capital required under [insert reference in state law equivalent to the Risk-Based Capital (RBC) for Health Organizations Model Act];
 - (2) An initial net worth of \$3,000,000; or
 - (3) At the commissioner's discretion, an amount greater than required under Paragraph (1) or (2), as indicated by a business plan and a projected risk-based capital calculation after the first full year of operation based on the most current NAIC Health Annual Statement Blank.

Section 17. Ongoing Net Worth and Capital Requirements

- A. A health maintenance organization shall maintain minimum net worth equal to the greater of \$2,500,000 or the amount necessary to maintain capital required pursuant to [insert reference to state law equivalent to the Risk-Based Capital for Health Organizations Model Act].
- B. The amount in Subsection A may be adjusted annually for inflation, at the commissioner's discretion.

Drafting Note: The following definition of “managed hospital payment basis” and formulation for ongoing net worth, based on the 1989 amended version of HMO Model Act, have been included for the benefit of states that have not adopted the Risk-Based Capital for Health Organizations Model Act:

“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. Examples of managed hospital payment basis agreements include but are not limited to payments on a DRG or per diem basis or where there is an agreement between a hospital and health maintenance organization and which are under common ownership or control.

- C. A health maintenance organization shall maintain a minimum net worth equal to the greater of \$2,500,000; or an amount equal to the sum of:
 - (1) Eight percent (8%) 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
 - (2) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

Section 18. Deposit Requirements

- A. Unless otherwise provided in this section, a 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 market value of not less than \$1,000,000.
- B. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.
- C. 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.
- D. The deposit shall be used to protect the interests of the health maintenance organization’s covered persons and to assure continuation of health care services to covered persons of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a rehabilitation, 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 the liquidation act.
- E. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, commissioner, or other official body of the state or jurisdiction of domicile for the protection of all covered persons, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

Section 19. Hold Harmless Provision Requirements for Covered Persons

- A. Except for coinsurance, deductibles or copayments as specifically provided in the evidence of coverage, in no event, including but not limited to nonpayment by the health maintenance organization, insolvency of the health maintenance organization or breach of contract among the health maintenance organization, risk bearing entity or participating provider, shall a risk bearing entity or participating provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization) acting on behalf of the covered person for covered services provided. No risk bearing entity or participating provider, nor any agent, trustee or assignee of the risk bearing entity or participating provider may maintain an action at law against a covered person to collect sums owed by the health maintenance organization.

- B. All contracts among health maintenance organizations, risk bearing entities, and participating providers shall include a hold harmless provision specifying protection for covered persons. Any attempted waiver or amendment in a manner materially adverse to the interests of covered persons of a hold harmless provision shall be null and void and unenforceable.
- C. The requirement of Subsection B shall be met by including a provision substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health maintenance organization or intermediary organization, insolvency of the health maintenance organization or intermediary organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health maintenance organization or intermediary organization) acting on behalf of the covered person for covered services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, copayments or services in excess of limits, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons.”

- D. (1) Any statement sent to a covered person shall clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.
- (2) All contracts among health maintenance organizations, risk bearing entities, and participating providers shall require that all statements sent to covered persons clearly state the amounts billed to the health maintenance organization and include a notice explaining that covered persons are not responsible for amounts owed by the health maintenance organization.
- (3) The notice requirements in this subsection shall be met by including in the statement to covered persons a provision substantially similar the following:

**NOTICE: YOU ARE NOT RESPONSIBLE FOR ANY AMOUNTS OWED
BY YOUR HEALTH MAINTENANCE ORGANIZATION**

- E. Any violation of the provisions of this section shall constitute an unfair trade practice pursuant to [insert reference to state insurance fraud statute] and shall subject the health care provider to monetary penalties in accordance with [insert reference to state insurance fraud statute] and notification to the [insert reference to appropriate licensing entity for type of provider].

Drafting Note: States that do not authorize insurance departments to take action against providers should not adopt Subsection E and should consider other options such as contacting the state attorney general’s office or other appropriate state official.

Drafting Note: States with consumer protection acts that provide covered persons with a private right of action should consider including a reference in Subsection E.

Section 20. Uncovered Expenditures Deposit

- A. If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with an organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of 120 percent of the health maintenance organization’s outstanding liability for uncovered expenditures for covered persons 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 (45) 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 18 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from 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. (1) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:
 - (a) A substitute deposit of cash or securities of equal amount and value is made;
 - (b) The fair market value exceeds the amount of the required deposit; or
 - (c) The required deposit under Subsection A is reduced or eliminated.(2) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.
- D. The deposit required under this section is in trust and may be used only as provided under 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 covered persons 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 the 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 by regulation prescribe the time, manner and form for filing claims under Subsection D.
- F. The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports deemed 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.

Section 21. Open Enrollment and Replacement Coverage in the Event of Insolvency

- A. Enrollment Period
 - (1) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of 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.
 - (2) 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 covered persons of the insolvent health maintenance organization, then the commissioner 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 so allocated 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 and in accordance with state law.

- (3) The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees that 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 shall offer the 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.

B. Replacement Coverage

- (1) "Discontinuance" shall mean 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.
- (2) A health maintenance organization providing replacement coverage hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization, shall immediately cover all covered persons who were validly covered under the previous health maintenance organization at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding health maintenance organization, regardless of any provisions of the contract relating to active employment, hospital confinement or pregnancy.

Drafting Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), in the group market, a succeeding carrier, including a health maintenance organization, is prohibited from including any nonconfinement rules in its plan of benefits and any actively-at-work rules provided in the succeeding carrier's plan of benefits must provide that absence from work due to any health status-related factor be treated as being actively-at-work.

- (3) 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 health maintenance organization's contract of replacement coverage that 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 covered persons validly covered under the prior carrier's contract or policy on the date of discontinuance.

Section 22. Investment Powers

With the exception of investments made in accordance with Section 7A(1) of this Act, the investment practices of a health maintenance organization shall be governed by [insert reference to state law equivalent to the NAIC Health Maintenance Organization Investment Guidelines].

Section 23. Accounting Practices

Every health maintenance organization shall maintain its financial records in accordance with [insert reference to state law equivalent to NAIC *Accounting Practices and Procedures Manual*].

Section 24. Fiduciary Responsibilities

- A. A director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of the health maintenance organization shall be responsible for the funds in a fiduciary relationship to the health maintenance organization.

- B. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on these employees and officers, directors and partners in an amount not less than \$1,000,000 for each health maintenance organization or a maximum of \$10,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or the sum prescribed by the commissioner.

Drafting Note: As an optional additional subsection, language may be included that would make the appropriate provisions of the state's insurance laws governing prohibitions or restrictions on activities of directors, officers and certain shareholders applicable to health maintenance organizations.

Section 25. Annual and Quarterly Financial Statement Filing Requirements

- A. (1) Every health maintenance organization shall file annual and quarterly financial statements, as provided in Paragraph (2), with the commissioner and with the National Association of Insurance Commissioners (NAIC).
- (2) The annual statement shall be filed by March 1 for the preceding year and a quarterly financial statement by May, August and November 15 for the preceding quarter.
- B. The annual and quarterly financial statements shall be prepared on the most current NAIC Health Annual Statement Blank in accordance with the NAIC Annual Statement Instructions and the NAIC *Accounting Practices and Procedures Manual*.

Section 26. Reporting Requirements

- A. (1) 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. The report shall be on forms prescribed by the commissioner.
- (2) In addition, the health maintenance organization shall file by March 1, unless otherwise stated:
 - (a) Audited financial statements on or before June 1;
 - (b) A list of participating providers in a form approved by the commissioner; and
 - (c) (i) A description of the grievance procedures; and
 - (ii) The total number of grievances handled through these procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.
- B. (1) Unless otherwise provided in this Act, a health maintenance organization shall file notice with the commissioner within thirty (30) days of the effective date of a change, describing any material modifications to the documents required to be filed with the application for a certificate of authority as set forth in Section 5B(1) and (2) of this Act.
- (2) Unless otherwise provided in this Act, a health maintenance organization shall file with the commissioner advance notice, or if advance notice is not practicable, notice filed as soon as possible, but in no event more than thirty (30) days after the effective date of a change, describing any material modifications to the health maintenance organization's operations as set forth in the information required by Section 5B of this Act that affects any of the following:
 - (a) The solvency of the health maintenance organization;
 - (b) The health maintenance organization's continued provision of health care services that it has contracted to provide;
 - (c) The manner in which the health maintenance organization conducts its business; or
 - (d) Any other matters the commissioner may prescribe by regulation.

- C. The commissioner may require additional reports as necessary to carry out the commissioner's duties under this Act.

Section 27. 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, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this Act. Notwithstanding any other law, which may be inconsistent, any two (2) 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 services by a health maintenance organization owned or operated by an insurer or its subsidiary.
- B. Notwithstanding any provision of insurance and hospital or medical service corporation laws [citations], 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 covered persons 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.

Section 28. Examinations

- A. The commissioner may make an examination of the affairs of a health maintenance organization, providers and risk bearing entities with which the health maintenance 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 not less frequently than once every five (5) years.
- B. An examination conducted under this section shall be performed in accordance with the provisions of [insert reference to state law equivalent to the NAIC Model Law on Examinations].
- C. The expenses of examinations under this section shall be assessed against the health maintenance organization being examined and remitted to the commissioner.
- D. In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state provided that the provisions of [insert state law equivalent to Section 3C of the NAIC Model Law on Examinations] are satisfied.

Section 29. Suspension or Revocation of Certificate of Authority

- A. A certificate of authority issued under this Act may be suspended or revoked, and an 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 5 of this Act, unless amendments to those submissions have been filed with and approved by the commissioner;
 - (2) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Sections 8 and 9 of this Act;
 - (3) The health maintenance organization does not provide or arrange for basic health care services;
 - (4) The health maintenance organization is unable to fulfill its obligations to furnish health care services;
 - (5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to covered persons or prospective covered persons;

- (6) The health maintenance organization has failed to correct any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

Drafting Note: States that have not adopted Risk Based Capital for Health Organizations Model Act should consider including a provision that provides for early warning and correction of insufficient net worth by a health maintenance organization.

- (7) The health maintenance organization has failed to implement internal grievance procedures in compliance with [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act];
- (8) The health maintenance organization has failed to implement the external review procedures required by [insert reference to state law equivalent to the Health Carrier External Review Model Act];

Drafting Note: States that have adopted Options 1 or 2 of the NAIC Health Carrier External Review Model Act should not adopt this provision.

- (9) The health maintenance organization, or any person acting on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;
- (10) The continued operation of the health maintenance organization would be hazardous to its covered persons;
- (11) The health maintenance organization has otherwise failed substantially to comply with this Act or any regulation adopted pursuant to this Act; or
- (12) The health maintenance organization or applicant has violated any other provision of the state insurance code.

Drafting Note: States that have adopted an Administrative Procedures Act should adopt Option A. States that have not adopted an Administrative Procedures Act should adopt Option B.

Option A.

- B. The provisions of the [insert reference to state Administrative Procedure Act] of this state shall apply to proceedings under this section.

Option B.

- B. (1) Suspension or revocation of a certificate of authority or the denial of an application 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 the suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of the thirty (30) day period.
- (2) If the health maintenance organization or applicant requests a hearing pursuant to this subsection the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail stating:
 - (a) A specific time for the hearing, which may not be less than twenty (20) days nor more than thirty (30) days after mailing of the notice of hearing; and
 - (b) A specific place for the hearing, which may be either in [location of regulatory body] or in the county where the health maintenance organization's or applicant's principal place of business is located.
- C. (1) With respect to individual contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall not:

- (a) Enroll any additional covered persons except newborn children or other newly acquired dependents of existing covered persons; and
 - (b) Engage in any advertising or solicitation.
- (2) With respect to group contracts, when the certificate of authority of a health maintenance organization is suspended, during the period of suspension, the health maintenance organization shall enroll additional enrollees and their eligible dependents and newly acquired eligible dependents of existing enrollees, including individuals who become newly acquired eligible dependents of an enrollee through marriage, birth or adoption or placement for adoption, who meet the requirements for special enrollment in accordance with [cite section of state law or regulation implementing the provisions of Section 2701(f) of the Public Health Service Act] or are otherwise eligible under the health benefit plan.

Drafting Note: Under Section 2701(f) of the Public Health Service Act, as amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for the group market, health maintenance organizations are required during special enrollment periods to enroll individual eligible employees and dependents of eligible employees and newly acquired dependents of already enrolled eligible employees, including individuals who become dependents through marriage, birth or adoption or placement for adoption. The language in Paragraph (2) is intended to reflect this requirement.

- D. When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit further operation of the organization found to be in the best interest of covered persons, to the end that covered persons will be afforded the greatest practical opportunity to obtain continuing health care coverage.
- E. A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

Section 30. Summary Orders and Supervision

- A. Whenever the commissioner determines that the financial condition of a health maintenance organization is such that its continued operation might be hazardous to covered persons, creditors, or the general public, or that it has violated any provision of this Act, the commissioner may, after notice and hearing, order the health maintenance organization to take action reasonably necessary to rectify the condition or violation, including but not limited to one or more of the following:
 - (1) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;
 - (2) Reduce the volume of new business being accepted;
 - (3) Reduce expenses by specified methods;
 - (4) Suspend or limit the writing of new business for a period of time;
 - (5) Increase the health maintenance organization's capital and surplus by contribution; or
 - (6) Take other steps 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 the health maintenance organization is subject shall be deemed a violation of this Act.
- C. The commissioner is authorized to adopt regulations to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to covered persons, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization. The 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 [insert reference to state law equivalent to Section 10 of the NAIC Rehabilitation and Liquidation Model Act].

Section 31. Rehabilitation, Liquidation or Conservation of Health Maintenance Organizations

- A. A 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 [insert reference to state rehabilitation law], or when in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to the covered persons or to the people of this state. Covered persons 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 covered persons shall have the same priority as established in [insert reference to state law relating to liquidation of insurers] for policyholders and beneficiaries of insureds of insurance companies. If a covered person is liable to a provider for services provided pursuant to and covered by the health benefit plan, that liability shall have the status of a covered person claim for distribution of general assets. A provider who is obligated by statute or agreement to hold covered persons harmless from liability for services provided pursuant to and covered by a health benefit plan shall have a priority of distribution of the general assets immediately following that of covered persons as described herein, and immediately preceding the priority of distribution described in [insert reference to state liquidation procedures].

Section 32. Penalties and Enforcement

- A. In addition to or in lieu of suspension or revocation of a certificate of authority or the denial of an application pursuant to Section 29 of this Act, the applicant or the health maintenance organization may be subjected to an administrative penalty of up to \$[insert number] for each cause for suspension or revocation or application denial.
- B.
 - (1) If the commissioner shall for any reason have cause to believe that a violation of this Act 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 the 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 the suspected violation; and, in the event it appears that a violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.
 - (2) 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 rule or order may result from a conference until the requirements of this section of this Act are satisfied.
- C. Notwithstanding any other provisions of this Act, if a health maintenance organization fails to comply with the net worth requirement of this Act or fails to correct its net worth to bring it into compliance with the requirements of this Act, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its covered persons.

Drafting Note: In addition to the actions provided in this section that a commissioner may use to enforce a health maintenance organization's compliance with the provisions of this Act, some states may authorize the commissioner to issue an order to a health maintenance organization or a representative of the health maintenance organization to cease and desist from engaging in an act or practice that is violation of this Act. In addition, the commissioner may also be authorized to institute an action seeking to obtain injunctive or other relief if the health maintenance organization fails to comply with the order to cease and desist. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

Section 33. Regulations

The commissioner may promulgate regulations to carry out the provisions of this Act. The rules and regulations shall be subject to review in accordance with [insert reference to state law relating to administrative rulemaking and review of rules].

Section 34. Statutory Construction and Relationship to Other Laws

- A. Except as otherwise provided in this Act, provisions of the insurance law and provisions of hospital or medical service corporation laws shall not be applicable to a health maintenance organization granted a certificate of authority under this Act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law 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 Act.
- 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 care professionals.
- C. Any health maintenance organization authorized under this Act shall not be deemed to be practicing medicine and shall be exempt from the provision of [insert reference to state law relating to the practice of medicine].

Section 35. Filings and Reports as Public Documents

All applications, filings and reports required under this Act shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 26 of this Act, and any other information that is considered privileged or confidential under state or federal law.

Section 36. Insurance Holding Company System Regulatory Act

All health maintenance organizations shall meet the requirements of [insert reference to state law equivalent to NAIC Insurance Holding Company System Regulatory Act].

Drafting Note: States that have not included health maintenance organizations within the scope of their state law equivalent to the NAIC Insurance Holding Company System Regulatory Act should not adopt this section.

Section 37. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 38. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1973 Proc. I 9, 11, 141, 192, 202-222 (adopted).
1973 Proc. II 139 (synopsis of model).
1974 Proc. I 12, 14, 405, 413 (amended).
1982 Proc. I 19, 28, 431, 498-499, 530-554 (amended and reprinted).
1989 Proc. I 9, 22, 180-181, 327, 331-335 (amended).
1989 Proc. II 13, 25-26, 40, 51-79 (amended and reprinted).
1990 Proc. I 6, 26, 171, 374-376, 377-379 (amended).
1991 Proc. I 9, 19-20, 86, 108 (technical amendment).
2002 Proc. 4th Quarter 278, 285-317 (amended and reprinted, adopted by task force).
2003 Proc. 1st Quarter 174 (adopted by parent committee).
2003 Proc. 2nd Quarter 12, 16 (adopted by Plenary).

HEALTH MAINTENANCE ORGANIZATION MODEL ACT

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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HEALTH MAINTENANCE ORGANIZATION MODEL ACT

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner**.

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	ALA. CODE §§ 27-21A-1 to 7-21A-32 (1986).	
Alaska	ALASKA STAT. §§ 21.86.010 to 21.86.900 (1990/2011).	
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1051 to 20-1069 (1973/1990) (“Health Care Service Organizations”).
Arkansas	ARK. CODE ANN. §§ 23-76-101 to 23-76-130 (1975/2013).	
California		CAL. HEALTH & SAFETY CODE §§ 1340 to 1399.64 (1979/2009) (“Knox-Keene Health Care Services Plan”); §§ 1374.60 to 1374.71 (1993/2009) (Point-of-service plans).
Colorado	COLO. REV. STAT. §§ 10-16-401 to 10-16-429 (1992/2013).	3 COLO. CODE REGS. § 702-4:4-7-1 (1999/2012).
Connecticut		CONN. GEN. STAT. §§ 33-179a to 33-179t (1971/2015) (“Health Care Centers”).
Delaware		DEL. CODE ANN. tit. 18, §§ 6401 to 6406 (1987) (Dept. of Public Health).
District of Columbia	D.C. CODE §§ 31-3401 to 31-3430 (1996/2004); D.C. MUN. REGS. tit. 26, §§ 3500 to 3599 (1999).	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Florida		FLA. STAT. §§ 641.17 to 641.3921 (1985/2013) (Includes point of service).
Georgia	GA. CODE ANN. §§ 33-21-1 to 33-21-28 (1979/1986).	
Guam	NO CURRENT ACTIVITY	
Hawaii	HAW. REV. STAT. §§ 432D-1 to 432D-24 (1996/2015).	
Idaho		IDAHO CODE ANN. §§ 41-3901 to 41-3932 (1974/1998).
Illinois	215 ILL. COMP. STAT. 125/1-2 to 125/6-19 (1974/2014) (Includes point of service).	BULLETIN 2013-13 (2013).
Indiana	IND. CODE §§ 27-13-1-1 to 27-13-33-2 (1994/2003).	IND. ADMIN. CODE tit. 760, §§ 1-70-1 to 1-70-8 (2005) (In case of receivership).
Iowa	IOWA CODE §§ 514B.1 to 514B.32 (1973/2009).	IOWA CODE § 514C.13 (1997) (Point-of-service).
Kansas	KAN. STAT. ANN. §§ 40-3201 to 40-3230 (1974/2000).	
Kentucky		KY. REV. STAT. ANN. §§ 304.38-010 to 304.38-230 (1982/2004).
Louisiana	LA. REV. STAT. ANN. §§ 22:241 to 22:270 (2009/2010).	
Maine	ME. REV. STAT. ANN. tit. 24-A, §§ 4201 to 4226 (1975/2001).	ME. REV. STAT. ANN. tit. 24-A, § 4202-A; § 4204-A; § 4207-A (1992) (Point of service provisions).
Maryland		MD. CODE ANN., INS. §§ 19-701 to 19-734 (1982/2013) (Health Code) (Includes point-of-service); MD. CODE REGS. § 31.12.06.01 (1997).
Massachusetts		MASS. GEN. LAWS ch. 176G, §§ 1 to 23 (1976/2013).
Michigan		MICH. COMP. LAWS §§ 500.3501 to 500.3580 (2000/2002).
Minnesota	MINN. STAT. §§ 62D.01 to 62D.30 (1973/2013) (Dept. of Health).	MINN. STAT. §§ 62Q.51 (1996) (Point-of-service).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Mississippi	MISS. CODE ANN. §§ 83-41-301 to 83-41-365 (1995).	
Missouri	MO. REV. STAT. §§ 354.400 to 354.550 (1983/2013).	
Montana	MONT. CODE ANN. §§ 33-31-101 to 33-31-405 (1987/2011).	
Nebraska	NEB. REV. STAT. §§ 44-3292 to 44-32180 (1990).	
Nevada		NEV. REV. STAT. §§ 695C.010 to 695C.350 (1973/2013).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-B:1 to 420-B:22 (1977/2011) (Includes point-of-service plans).
New Jersey	N.J. REV. STAT. §§ 26:2J-1 to 26:2J-30 (1973) (Dept. of Health).	BULLETIN 2009-010 (2009).
New Mexico	N.M. STAT. ANN. §§ 59A-46-1 to 59A-46-32 (1985/1994).	
New York		N.Y. PUB. HEALTH LAW §§ 4400 to 4413 (1976/2013).
North Carolina	N.C. GEN. STAT. §§ 58-67-1 to 58-67-185 (1979/2003).	11 N.C. ADMIN. CODE §§ 1401 to 1404 (1994) (Point of service).
North Dakota	N.D. CENT. CODE §§ 26.1-18.1-01 to 26.1-18.1-25 (1993/2005).	
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	OHIO REV. CODE ANN. §§ 1751.01 to 1751.89 (1999/2014).	
Oklahoma	OKLA. STAT. tit. 36, §§ 6901 to 6936 (2003/2005).	
Oregon		OR. REV. STAT. §§ 750.003 to 750.075 (1985/2014).
Pennsylvania		40 PA. STAT. ANN. §§ 83-101 to 83-119 (1981); 31 PA. CODE §§ 301.201 to 301.204 (Statement of policy on point of service).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Puerto Rico		P.R. LAWS ANN. tit. 26, §§ 1901 to 1927.
Rhode Island	R.I. GEN. LAWS §§ 27-41-1 to 27-41-34 (1983/2005).	
South Carolina	S.C. CODE ANN. §§ 38-33-10 to 38-33-300 (1988/2000).	
South Dakota		S.D. CODIFIED LAWS §§ 58-41-1 to 58-41-97 (1974/2014).
Tennessee	TENN. CODE ANN. §§ 56-32-101 to 56-32-138 (1986/2013).	
Texas	TEX. INS. CODE ANN. §§ 843.001 to 843.464 (2003/2005).	BULLETIN B-0008-13 (2013).
Utah		UTAH CODE ANN. §§ 31A-8-101 to 31A-8-501 (1986/2014) (Includes point-of-service provision); UTAH ADMIN. CODE r. 590-76 (2009).
Vermont	VT. STAT. ANN. tit. 8, §§ 5101 to 5113 (1979/2014) (portions of model).	
Virgin Islands	NO CURRENT ACTIVITY	
Virginia	VA. CODE ANN. §§ 38.2-4300 to 38.2-4321 (1986/2013).	VA. CODE ANN. § 38.2-3407.12 (1998/2014) (Point of service); § 1016.1 (2007); 14 VA. ADMIN. CODE 5-211-10 (2011).
Washington		WASH. REV. CODE ANN. §§ 48.46.010 to 48.46.920 (1975/2013) (portions of model).
West Virginia	W. VA. CODE §§ 33-25A-1 to 33-25A-35 (1977/2013).	
Wisconsin		WIS. STAT. §§ 609.91 to 609.98 (1985/1989); § 628-36 (Providing that commissioner may make rules for HMOs); WIS. ADMIN. CODE INS. §§ 9.02 to 9.15 (2000/2002) (Financial standards); §§ 9.30 to 9.42 (2000/2001) (Market conduct standards).
Wyoming	WYO. STAT. ANN. §§ 26-34-101 to 26-34-134 (1986/2004).	