PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the "Prepaid Limited Health Service Organization Act of [insert state]."

Section 2. Definitions

As used in this Act, unless otherwise defined in this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: This model uses the term "commissioner." Each state should use the title of its chief insurance supervisory official.

B. "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

C. "Evidence of coverage" means the certificate, agreement or contract issued pursuant to Section 9 of this Act setting forth the coverage to which an enrollee is entitled.

D. "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical or emergency services except as these services are provided incident to the limited health services set forth in the preceding sentence.

E. "Prepaid limited health service organization" means any corporation, partnership or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Prepaid limited health service organization does not include:

(1) An entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(2) An entity that meets the requirements of Section 7 of this Act; or

(3) A provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a prepaid limited health service organization or with an entity described in Paragraph (1) or (2) of this definition.

Drafting Note: The primary objective of this model legislation is to provide the means to regulate limited health service plans, which currently escape regulation in many states. At the same time, this model act seeks to avoid unnecessary duplication of regulation for other entities, which currently are authorized pursuant to state law to provide limited health services on a prepayment or other basis or to indemnify for such services. Certain of these entities, however, which do not meet the prepaid limited health service organization definition, may provide limited health services on a per capita or fixed prepayment basis by fulfilling the requirements of Section 7.

Each state should consider whether the repeal of existing statutes governing single health care service organizations, *e.g.*, for-profit dental plan organization statutes, nonprofit dental service corporation statutes, vision care statutes, will advance the purpose of this Act in its own jurisdiction.

F. "Provider" means a physician, dentist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services.

H. "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

Section 3. Certificate of Authority Required

No person, corporation, partnership or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this Act.

Section 4. Application for Certificate of Authority

An application for a certificate of authority to operate a prepaid limited health service organization shall be filed with the commissioner on a form prescribed by the commissioner. The application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

A. A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments to these documents;

B. A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

C. A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

D. A statement generally describing the applicant, its facilities, personnel and the limited health services to be offered;

E. A copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

F. A copy of the form of any contract made, or to be made between the applicant and any person listed in Subsection C of this section;

G. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management and subcontracting for the provision of limited health services to enrollees;

H. A copy of the form of any group contract that is to be issued to employers, unions, trustees or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

I. A copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this Act;

J. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

K. A schedule of rates and charges;

L. A description of the proposed method of marketing;

M. A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with [insert citation to appropriate section of insurance code];

N. A description of the complaint procedures to be established and maintained as required under Section 13 of this Act;

O. A description of the quality assessment and utilization review procedures to be utilized by the applicant;

P. A description of how the applicant will comply with Section 18 of this Act;

Q. The fee for issuance of a certificate of authority provided in Section 24 of this Act; and

R. Such other information as the commissioner may reasonably require to make the determinations required by this Act.

Section 5. Issuance of Certificate of Authority; Denial

A. Following receipt of an application filed pursuant to Section 4, the commissioner shall review the application and notify the applicant of any deficiencies. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) The requirements of Section 4 have been fulfilled;

(2) The individuals responsible for conducting the applicant's affairs are competent, trustworthy and possess good reputations, and have had appropriate experience, training or education;

(3) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(a) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments and other patient charges used in connection therewith;

(b) The adequacy of working capital, other sources of funding, and provisions for contingencies;

(c) Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(d) The manner in which the requirements of Section 18 of this Act have been fulfilled;

(4) The agreements with providers for the provision of limited health services contain the provisions required by Section 17 of this Act; and

(5) Any deficiencies identified by the commissioner have been corrected.

B. If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization shall have [insert number] days from the date of receipt of the notice to request a hearing before the commissioner pursuant to [insert citation to state's administrative procedures act].

Section 6. Effect on Organizations Operating on Effective Date of this Act

Within [insert number] days after the effective date of this Act, every prepaid limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the commissioner. Each such organization may continue to operate during the pendency of its application. In the event an application is denied under this section, the applicant will then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

Section 7. Filing Requirements for Authorized Entities

A. An entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health, hospital or medical service corporation or a fraternal benefit society and that is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the commissioner the information requested by Section 4D, E, G, H, J, K, L and O and any subsequent material modification or addition thereto.

B. If the commissioner disapproves the filing, the procedures set forth in Section 5B of this Act shall be followed.

Drafting Note: This section enables specified entities, which already are authorized pursuant to state law to provide certain health benefits or services, to expand their product offerings to include limited health services on a per capita or fixed prepayment basis. To do so, the entities must file an attenuated application for approval pursuant to this Act. The attenuated filing is designed to provide the commissioner with the information essential to understanding the product offering. Of course, these entities remain subject to all of the financial and other requirements of their enabling legislation. Entities that already are authorized pursuant to state law to provide limited health services on a per capita or fixed prepayment basis fall outside the ambit of this Act.

Section 8. Changes in Rates and Benefits, Material Modifications; Addition of Limited Health Services

A. A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any change in rates, charges or benefits and of any material modification of any matter or document furnished pursuant to Section 4, together with supporting documents necessary to fully explain the change or modification. If the commissioner does not disapprove the filing within [insert number] days of its filing, the filing shall be deemed approved.

B. If a prepaid limited health service organization desires to add one or more limited health services, it shall file a notice with the commissioner and, at the same time, shall submit the information required by Section 4 (if different from that filed with the prepaid limited health service organization's application), and shall demonstrate compliance with Sections 17, 18 and 24. If the commissioner does not disapprove the filing within [insert number] days of its filing, the filing shall be deemed approved.

C. If such filings are disapproved, the commissioner shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization shall have [insert number] days from the date of receipt of notice to request a hearing before the commissioner pursuant to [insert citation to state's administrative procedures act].

Section 9. Evidence of Coverage

A. Every subscriber shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The limited health services to which each enrollee is entitled;

(2) Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any deductible, copayment or other charges;

(3) Where and in what manner information is available as to where and how services may be obtained; and

(4) The method for resolving complaints.

B. Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

Section 10. Rates and Charges

The rates and charges shall be reasonable in relation to the services provided. The commissioner may request information from the prepaid limited health service organization supporting the appropriateness of the rates and charges.

Section 11. Construction with Other Laws

A. (1) A prepaid limited health service organization organized under the laws of this state shall be deemed to be a domestic insurer for purposes of [insert citation to the state's insurance holding company system regulatory act] unless specifically exempted in writing from one or more of the provisions of that act by the commissioner.

(2) A prepaid limited health service organization shall be subject to [insert citations to pertinent sections of state's unfair insurance trade practices act and penalty provisions governing insurance companies].

(3) No other provision of the insurance code shall apply to a prepaid limited health service organization unless such an organization is specifically mentioned therein.

Drafting Note: Each state should review its unfair insurance trade practices act and penalty provisions governing insurance companies to determine if any of its provisions should not apply to prepaid limited health service organizations.

B. The provision of limited health services by a prepaid limited health service organization or other entity pursuant to this Act shall not be deemed to be the practice of medicine or other healing arts.

Drafting Note: The intent of Subsection B of this section is to specify that prepaid limited health service organizations and other entities operating pursuant to this Act are not involved in the practice of medicine or in the practice of any other form of health services. Since the statutes in a number of states define one or more types of health services as other than the practice of medicine, this exclusion should contain references to the applicable sections of a state's licensing provisions.

C. Solicitation to arrange for or provide limited health services in accordance with this Act shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Section 12. Nonduplication of Coverage

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health or hospital or medical service corporation or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services (whether in the form of services, supplies or reimbursement), insofar as the coverage or service is provided in accordance with this Act under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health or hospital or medical service corporation or a fraternal benefit society.

Drafting Note: A number of state laws mandate coverage for various health care benefits and services. Under current law, health maintenance organizations, accident and health insurance companies, nonprofit health, hospital or medical service corporations, and fraternal benefit societies must include the mandated benefit in a group policy or contract without exception. This section permits the exclusion of the mandated benefit or services from the policy or contract to the extent that it is provided as a limited health service. In this manner, the insureds/covered persons receive the benefit mandated by law, but there is no expensive duplication. Without this provision, employers would have to pay twice for mandated benefits for limited health services. Such a result would severely limit the development and competitiveness of plans providing limited health services, which would be to the detriment of employers and consumers.

Section 13. Complaint System

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. Nothing herein shall be construed to preclude an enrollee or a provider from filing a complaint with the commissioner or as limiting the commissioner's ability to investigate such complaints.

Section 14. Examination of Organization

A. The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every [insert number] years.

B. Every prepaid limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

C. The reasonable expenses of an examination under this section shall be charged to the 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.

Section 15. Investments

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines established by the National Association of Insurance Cmmissioners for investments by health maintenance organizations.

Section 16. Agents

No individual may apply, procure, negotiate or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, health, hospital or medical service contracts, or health maintenance organization contracts.

Section 17. Contracts with Providers

All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis shall contain or shall be construed to contain the following terms and conditions:

A. In the event the prepaid limited health service organization fails to pay for limited health services for any reason whatsoever, including but not limited to, insolvency or breach of contract, the enrollees shall not be liable to the provider for any sums owed to the provider under the contract.

B. No provider, agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the prepaid limited health service organization.

C. These provisions do not prohibit collection of uncovered charges consented to by enrollees or collection of copayments from enrollees.

D. These provisions shall survive the termination of the contract, regardless of the reason giving rise to termination.

E. Termination of the contract shall not release the provider from completing procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed [insert number] days, at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of the contract.

F. Any amendment to these foregoing provisions of the contract must be submitted to and be approved by the commissioner prior to becoming effective.

Section 18. Protection Against Insolvency; Deposit

A. (1) Except as approved in accordance with Subsection D of this section, each prepaid limited health service organization shall at all times have and maintain tangible net equity equal to the greater of:

(a) $50,000; or

(b) Two percent (2%) of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(2) A prepaid limited health service organization that has uncovered expenses in excess of $50,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to twenty-five percent (25%) of the uncovered expense in excess of $50,000 in addition to the tangible net equity required by Subsection A(1) of this section.

B. For the purpose of this section, "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due.

C. (1) Each prepaid limited health service organization shall deposit with the commissioner or 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 is acceptable to the commissioner in an amount equal to $25,000 plus twenty-five percent (25%) of the tangible net equity required in Subsection A of this section; provided, however, that the deposit shall not be required to exceed $100,000.

(2) The deposit shall be an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(3) All income from deposits shall be an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(4) The deposit shall be used to protect the interests of the prepaid limited health service organization's enrollees and to assure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to provisions of the liquidation act.

(5) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

D. Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of Subsection A of this section for any period of time the commissioner deems proper upon a finding that either (1) the prepaid limited health service organization has a net equity of at least $5,000,000; or (2) an entity having a net equity of at least $5,000,000 furnishes to the commissioner a written commitment, acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

E. For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered a covered expense.

Drafting Note: Due to the limited scope of services provided and the limited underwriting risks associated with prepaid limited health service organizations, the tangible net equity requirements are lower than for full-service health maintenance organizations. In addition, this section provides suggested variable tangible net equity standards to take into account variations in plan size and amounts of uncovered expenses.

Section 19. Officers and Employees Fidelity Bond

A. A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than [insert amount] or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in compliance with [insert citation to insurance code], shall satisfy the requirements of this subsection.

B. In lieu of the bond specified in Subsection A of this section, a prepaid limited health service organization may deposit with the [insert appropriate state authority] cash or securities or other investments of the types set forth in Section 15 of this Act. Such a deposit shall be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

Section 20. Reports

A. Every prepaid limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

B. The report shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the organization, including its balance sheet, income statement and statement of changes in financial position for the preceding year, certified by an independent public accountant or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which shall be consolidating financial statements of the prepaid limited health service organization;

(2) The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year; and

(3) Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out his or her duties under this Act.

C. The commissioner may require more frequent reports containing such information as is necessary to enable the commissioner to carry out his or her duties under this Act.

D. The commissioner may assess a fine of up to $100 per day for each day any required report is late, and the commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

Section 21. Suspension or Revocation of Certificate of Authority

A. The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization pursuant to this Act upon determining that any of the following conditions exist:

(1) The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to Section 4 of this Act, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The prepaid limited health service organization issues an evidence of coverage or uses rates or charges that do not comply with the requirements of Sections 9 and 10 of this Act;

(3) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) The prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) The tangible net equity of the prepaid limited health service organization is less than that required by Section 18 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) The prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by Section 13 of this Act;

(7) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(8) The prepaid limited health service organization has otherwise failed to comply with this Act.

B. If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty (60) days thereafter for a hearing on the matter in accordance with the [insert citation to state's administrative procedures act].

C. When the certificate of authority of a prepaid limited health service 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 such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

Section 22. Penalties

In lieu of any penalty specified elsewhere in this Act, or when no penalty is specifically provided, whenever a prepaid limited health service organization or other person, corporation, partnership or entity subject to this Act has been found, pursuant to [insert citation to the appropriate sections of the state's administrative procedures act] to have violated any provision of this Act, the commissioner may:

A. Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

B. Impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000.

Section 23. Rehabilitation, Conservation or Liquidation

A. Any rehabilitation, conservation or liquidation of a prepaid limited health service organization shall be deemed to be the rehabilitation, conservation or liquidation of an insurance company and shall be conducted pursuant to [insert citations to statutory sections governing the rehabilitation, liquidation or conservation of insurance companies].

B. A prepaid limited health service organization shall not be subject to the laws and regulations governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a prepaid limited health service organization.

Section 24. Fees

Every prepaid limited health service organization subject to this Act shall pay to the commissioner the following fees:

A. For filing an application for a certificate of authority or amendment thereto—[insert amount];

B. For filing a material modification or addition of a limited health service—[insert amount];

C. For filing each annual report—[insert amount]; and

D. For filing periodic reports as required by the commissioner—[insert amount].

Section 25. Confidentiality

A. Any information pertaining to the diagnosis, treatment or health of any enrollee obtained from the person or from a provider by a prepaid limited health service organization and any contract with providers submitted pursuant to the requirements of this Act shall be held in confidence and shall not be disclosed to any person except:

(1) To the extent that it may be necessary to carry out the purposes of this Act;

(2) Upon the express consent of the enrollee or applicant, provider or prepaid limited health service organization, as appropriate;

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) In the event of claim or litigation wherein the data or information is relevant.

B. With respect to any information pertaining to the diagnosis, treatment or health of any enrollee or applicant, a prepaid limited health service organization shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the prepaid limited health service organization is entitled to claim.

C. In addition, any information provided to the commissioner that constitutes a trade secret, is privileged information, or is part of a department investigation or examination shall be held in confidence.

Section 26. Taxes

The same [tax/tax rates] provided for in [insert citation to state's health maintenance organization act] shall be imposed upon each prepaid limited health service organization, and the organization also shall be entitled to the same tax deductions, reductions, abatements and credits that health maintenance organizations are entitled to receive.

Drafting Note: The bracketed language in the first sentence of this section acknowledges that there may be different types of health maintenance organization taxes. Each state should review the applicability and appropriateness of extending any health maintenance organization taxes or tax rates that are in place to prepaid limited health service organizations. This review should consider: (1) the goals of, and reasoning for, the health maintenance organization taxes; (2) the significantly lower average per enrollee revenue of prepaid limited health service organizations as compared with that of health maintenance organizations; and (3) the applicability of equivalent health maintenance organization deductions, reductions, abatements and credits to prepaid limited health service organizations.

Section 27. Severability

If any section, term or provision of this Act shall be adjudged invalid for any reason by a court of competent jurisdiction, the judgment shall not affect, impair or invalidate any other section, term or provision of this Act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

Section 28. Regulations

The commissioner may, after notice and hearing, promulgate regulations to carry out the provisions of this Act.

Section 29. Effective Date

The effective date of this Act shall be [insert date].

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

1989 Proc. I 9, 24-25, 703, 755, 796-804 (adopted).

PREPAID LIMITED HEALTH SERVICE ORGANIZATION MODEL ACT

The NAIC amended this model during the 2007 Summer National Meeting. These amendments were adopted as guidelines under the NAIC's model laws process. The 2007 2nd Quarter Guideline Amendments are highlighted in grey.

Table of Contents

Section 1. Short Title

This Act shall be known and may be cited as the "Prepaid Limited Health Service Organization Act of [insert state]."

Section 2. Purpose and Intent

The purpose of this model Act is to provide the means to regulate limited health service organizations, including Medicare Prescription Drug Plans (PDPs), that is fair and efficient, and promotes the continued solvency of prepaid limited health service organizations. At the same time, this model act seeks to avoid unnecessary duplication of regulation for other entities, which currently are authorized pursuant to state law to provide limited health services on a prepayment or other basis or to indemnify for such services. Certain of these entities, however, which do not meet the prepaid limited health service organization definition, may provide limited health services on a per capita or fixed prepayment basis by fulfilling the requirements of Section 8 of this Act.

Each state should consider whether the repeal of existing statutes governing single health care service organizations, *e.g.*, for-profit dental plan organization statutes, nonprofit dental service corporation statutes, vision care statutes, will advance the purpose of this Act in its own jurisdiction.

This Act is designed to operate in conjunction with other state laws that establish standards for the regulation of health plans, 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 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.

Section 3. Definitions

As used in this Act, unless otherwise defined in this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: This model uses the term "commissioner." Each state should use the title of its chief insurance supervisory official.

B. "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

C. "Evidence of coverage" means the certificate, agreement or contract issued pursuant to Section 9 of this Act setting forth the coverage to which an enrollee is entitled.

D. (1) "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services.

(2) Limited health service shall not include hospital, medical, surgical or emergency services except as these services are provided incident to the limited health services set forth in the preceding sentence.

E. (1) "Prepaid limited health service organization" means any corporation, partnership or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees.

(2) Prepaid limited health service organization does not include:

(a) An entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(b) An entity that meets the requirements of Section 8 of this Act; or

(c) A provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a prepaid limited health service organization or with an entity described in Subparagraph (a) or (b) of this Paragraph.

F. "Provider" means a physician, dentist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services.

G. "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

Section 4. Certificate of Authority Required

No person, corporation, partnership or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this Act.

Section 5. Application for Certificate of Authority

A. An application for a certificate of authority to operate a prepaid limited health service organization shall be filed with the commissioner on a form prescribed by the commissioner.

B. The application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

(1). A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments to these documents;

(2). A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

(3). A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

(4). A statement generally describing the applicant, its facilities, personnel and the limited health services to be offered;

(5). A copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6). A copy of the form of any contract made, or to be made between the applicant and any person listed in Paragraph (3) of this section;

(7). A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management and subcontracting for the provision of limited health services to enrollees;

(8). A copy of the form of any group contract that is to be issued to employers, unions, trustees or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9). A copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this Act;

(10). A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(11). A schedule of rates and charges;

(12). A description of the proposed method of marketing;

(13). A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with [insert citation to appropriate section of insurance code];

(14). A description of the complaint procedures to be established and maintained as required under Section 14 of this Act;

(15). A description of the quality assessment and utilization review procedures to be utilized by the applicant;

(16). A description of how the applicant will comply with Section 19 of this Act;

(17). The fee for issuance of a certificate of authority provided in Section 25 of this Act; and

(18). Such other information as the commissioner may reasonably require to make the determinations required by this Act.

Section 6. Issuance of Certificate of Authority; Denial

A. Following receipt of an application filed pursuant to Section 5, the commissioner shall review the application and notify the applicant of any deficiencies.

B. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) The requirements of Section 5 have been fulfilled;

(2) The individuals responsible for conducting the applicant's affairs are competent, trustworthy and possess good reputations, and have had appropriate experience, training or education;

(3) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(a) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments and other patient charges used in connection therewith;

(b) The adequacy of working capital, other sources of funding, and provisions for contingencies;

(c) Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(d) The manner in which the requirements of Section 18 of this Act have been fulfilled;

(4) The agreements with providers for the provision of limited health services contain the provisions required by Section 18 of this Act; and

(5) Any deficiencies identified by the commissioner have been corrected.

C. If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The prepaid limited health service organization shall have [insert number] days from the date of receipt of the notice to request a hearing before the commissioner pursuant to [insert citation to state's administrative procedures act].

Section 7. Effect on Organizations Operating on Effective Date of this Act

Within [insert number] days after the effective date of this Act, every prepaid limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the commissioner. Each such organization may continue to operate

during the pendency of its application. In the event an application is denied under this section, the applicant will then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

Section 8. Filing Requirements for Authorized Entities

A. An entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health, hospital or medical service corporation or a fraternal benefit society and that is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the commissioner the information requested by Paragraphs (4), (5), (7), (8), (10), (11), (12) and (15) of Section 5B and any subsequent material modification or addition thereto.

B. If the commissioner disapproves the filing, the procedures set forth in Section 6C of this Act shall be followed.

Drafting Note: This section enables specified entities, which already are authorized pursuant to state law to provide certain health benefits or services, to expand their product offerings to include limited health services on a per capita or fixed prepayment basis. To do so, the entities must file an attenuated application for approval pursuant to this Act. The attenuated filing is designed to provide the commissioner with the information essential to understanding the product offering. Of course, these entities remain subject to all of the financial and other requirements of their enabling legislation. Entities that already are authorized pursuant to state law to provide limited health services on a per capita or fixed prepayment basis fall outside the ambit of this Act.

Section 9. Changes in Rates and Benefits, Material Modifications; Addition of Limited Health Services

A. A prepaid limited health service organization shall file with the commissioner prior to use, a notice of any change in rates, charges or benefits and of any material modification of any matter or document furnished pursuant to Section 5 of this Act, together with supporting documents necessary to fully explain the change or modification. If the commissioner does not disapprove the filing within [insert number] days of its filing, the filing shall be deemed approved.

B. If a prepaid limited health service organization desires to add one or more limited health services, it shall file a notice with the commissioner and, at the same time, shall submit the information required by Section 4 (if different from that filed with the prepaid limited health service organization's application), and shall demonstrate compliance with Sections 18, 19 and 25 of this Act. If the commissioner does not disapprove the filing within [insert number] days of its filing, the filing shall be deemed approved.

C. If such filings are disapproved, the commissioner shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization shall have [insert number] days from the date of receipt of notice to request a hearing before the commissioner pursuant to [insert citation to state's administrative procedures act].

Section 10. Evidence of Coverage

A. Every subscriber shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The limited health services to which each enrollee is entitled;

(2) Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any deductible, copayment or other charges;

(3) Where and in what manner information is available as to where and how services may be obtained; and

(4) The method for resolving complaints.

B. Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

Section 11. Rates and Charges

The rates and charges shall be reasonable in relation to the services provided. The commissioner may request information from the prepaid limited health service organization supporting the appropriateness of the rates and charges.

Section 12. Construction with Other Laws

A. (1) A prepaid limited health service organization organized under the laws of this state shall be deemed to be a domestic insurer for purposes of [insert citation to the state's insurance holding company system regulatory act] unless specifically exempted in writing from one or more of the provisions of that act by the commissioner.

(2) A prepaid limited health service organization shall be subject to [insert citations to pertinent sections of state's unfair insurance trade practices act and penalty provisions governing insurance companies].

(3) No other provision of the insurance code shall apply to a prepaid limited health service organization unless such an organization is specifically mentioned therein.

Drafting Note: Each state should review its unfair insurance trade practices act and penalty provisions governing insurance companies to determine if any of its provisions should not apply to prepaid limited health service organizations.

B. The provision of limited health services by a prepaid limited health service organization or other entity pursuant to this Act shall not be deemed to be the practice of medicine or other healing arts.

Drafting Note: The intent of Subsection B of this section is to specify that prepaid limited health service organizations and other entities operating pursuant to this Act are not involved in the practice of medicine or in the practice of any other form of health services. Since the statutes in a number of states define one or more types of health services as other than the practice of medicine, this exclusion should contain references to the applicable sections of a state's licensing provisions.

C. Solicitation to arrange for or provide limited health services in accordance with this Act shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Section 13. Nonduplication of Coverage

Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health or hospital or medical service corporation or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services (whether in the form of services, supplies or reimbursement), insofar as the coverage or service is provided in accordance with this Act under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health or hospital or medical service corporation or a fraternal benefit society.

Drafting Note: A number of state laws mandate coverage for various health care benefits and services. Under current law, health maintenance organizations, accident and health insurance companies, nonprofit health, hospital or medical service corporations, and fraternal benefit societies must include the mandated benefit in a group policy or contract without exception. This section permits the exclusion of the mandated benefit or services from the policy or contract to the extent that it is provided as a limited health service. In this manner, the insureds/covered persons receive the benefit mandated by law, but there is no expensive duplication. Without this provision, employers would have to pay twice for mandated benefits for limited health services. Such a result would severely limit the development and competitiveness of plans providing limited health services, which would be to the detriment of employers and consumers.

Section 14. Complaint System

Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. Nothing herein shall be construed to preclude an enrollee or a provider from filing a complaint with the commissioner or as limiting the commissioner's ability to investigate such complaints.

Section 15. Examination of Organization

A. The commissioner may examine the affairs of any prepaid limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every [insert number] years.

B. Every prepaid limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

C. The reasonable expenses of an examination under this section shall be charged to the 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.

Section 16. Investments

The funds of a prepaid limited health service organization shall be invested only in accordance with the guidelines established by the National Association of Insurance Cmmissioners for investments by health maintenance organizations.

Section 17. Agents

No individual may apply, procure, negotiate or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, health, hospital or medical service contracts, or health maintenance organization contracts.

Section 18. Contracts with Providers

All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis shall contain or shall be construed to contain the following terms and conditions:

A. In the event the prepaid limited health service organization fails to pay for limited health services for any reason whatsoever, including but not limited to, insolvency or breach of contract, the enrollees shall not be liable to the provider for any sums owed to the provider under the contract.

B. No provider, agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the prepaid limited health service organization.

C. These provisions do not prohibit collection of uncovered charges consented to by enrollees or collection of copayments from enrollees.

D. These provisions shall survive the termination of the contract, regardless of the reason giving rise to termination.

E. Termination of the contract shall not release the provider from completing procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed [insert number] days, at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of the contract.

F. Any amendment to these foregoing provisions of the contract must be submitted to and be approved by the commissioner prior to becoming effective.

Section 19. Protection Against Insolvency; Deposit

A. A prepaid limited health service organization shall maintain a minimum tangible net equity equal to the greater of $100,000 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].

Drafting Note: The following alternate Subsection A, based on the 1989 version of the Prepaid Limited Health Service Organization Model Act, has been included for the benefit of states that have not adopted the Risk-Based Capital for Health Organizations Model Act:

B. (1) Except as approved in accordance with Subsection D of this section, each prepaid limited health service organization shall at all times have and maintain tangible net equity equal to the greater of:

(a) $100,000; or

(b) Two percent (2%) of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(2) A prepaid limited health service organization that has uncovered expenses in excess of $100,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to twenty-five percent (25%) of the uncovered expense in excess of $100,000 in addition to the tangible net equity required by Subsection (B)(1) of this section.

C. For the purpose of this section, "net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due.

D. (1) Each prepaid limited health service organization shall deposit with the commissioner or 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 is acceptable to the commissioner in an amount equal to $50,000 plus twenty-five percent (25%) of the tangible net equity required in Subsection A of this section; provided, however, that the deposit shall not be required to exceed $200,000.

(2) The deposit shall be an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(3) All income from deposits shall be an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(4) The deposit shall be used to protect the interests of the prepaid limited health service organization's enrollees and to assure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to provisions of the liquidation act.

(5) The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

E. Upon application by a prepaid limited health service organization, the commissioner may waive some or all of the requirements of Subsection A of this section for any period of time the commissioner deems proper upon a finding that either (1) the prepaid limited health service organization has a net equity of at least $10,000,000; or (2) an entity having a net equity of at least $10,000,000 furnishes to the commissioner a written commitment, acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

F. For the purposes of this section, "uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health organization (1) for which an enrollee may be liable in the event of the insolvency of the organization and (2) for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered a covered expense.

Drafting Note: Due to the limited scope of services provided and the limited underwriting risks associated with prepaid limited health service organizations, the tangible net equity requirements are lower than for full-service health maintenance organizations. In addition, this section provides suggested variable tangible net equity standards to take into account variations in plan size and amounts of uncovered expenses.

Section 20. Officers and Employees Fidelity Bond

A. A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than [$20,000,000] or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines agent resident in this state in compliance with [insert citation to insurance code], shall satisfy the requirements of this subsection.

B. In lieu of the bond specified in Subsection A of this section, a prepaid limited health service organization may deposit with the [insert appropriate state authority] cash or securities or other investments of the types set forth in Section 16 of this Act. Such a deposit shall be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

Section 21. Reports

A. Every prepaid limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

B. The report shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the organization, including its balance sheet, income statement and statement of changes in financial position for the preceding year, certified by an independent public accountant or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which shall be consolidating financial statements of the prepaid limited health service organization;

(2) The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year; and

(3) Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out his or her duties under this Act.

C. The commissioner may require more frequent reports containing such information as is necessary to enable the commissioner to carry out his or her duties under this Act.

D. The commissioner may assess a fine of up to $100 per day for each day any required report is late, and the commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

Section 22. Suspension or Revocation of Certificate of Authority

A. The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization pursuant to this Act upon determining that any of the following conditions exist:

(1) The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to Section 5 of this Act, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The prepaid limited health service organization issues an evidence of coverage or uses rates or charges that do not comply with the requirements of Sections 10 and 11 of this Act;

(3) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) The prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) The tangible net equity of the prepaid limited health service organization is less than that required by Section 19 of this Act or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) The prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by Section 14 of this Act;

(7) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees; or

(8) The prepaid limited health service organization has otherwise failed to comply with this Act.

B. If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty (60) days thereafter for a hearing on the matter in accordance with the [insert citation to state's administrative procedures act].

C. When the certificate of authority of a prepaid limited health service 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 such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

Section 23. Penalties

In lieu of any penalty specified elsewhere in this Act, or when no penalty is specifically provided, whenever a prepaid limited health service organization or other person, corporation, partnership or entity subject to this Act has been found, pursuant to [insert citation to the appropriate sections of the state's administrative procedures act] to have violated any provision of this Act, the commissioner may:

A. Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

B. Impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000.

Section 24. Rehabilitation, Conservation or Liquidation

A. Any rehabilitation, conservation or liquidation of a prepaid limited health service organization shall be deemed to be the rehabilitation, conservation or liquidation of an insurance company and shall be conducted pursuant to [insert citations to statutory sections governing the rehabilitation, liquidation or conservation of insurance companies].

B. A prepaid limited health service organization shall not be subject to the laws and regulations governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a prepaid limited health service organization.

Section 25. Fees

Every prepaid limited health service organization subject to this Act shall pay to the commissioner the following fees:

A. For filing an application for a certificate of authority or amendment thereto—[insert amount];

B. For filing a material modification or addition of a limited health service—[insert amount];

C. For filing each annual report—[insert amount]; and

D. For filing periodic reports as required by the commissioner—[insert amount].

Section 26. Confidentiality

A. Any information pertaining to the diagnosis, treatment or health of any enrollee obtained from the person or from a provider by a prepaid limited health service organization and any contract with providers submitted pursuant to the requirements of this Act shall be held in confidence and shall not be disclosed to any person except:

(1) To the extent that it may be necessary to carry out the purposes of this Act;

(2) Upon the express consent of the enrollee or applicant, provider or prepaid limited health service organization, as appropriate;

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) In the event of claim or litigation wherein the data or information is relevant.

B. With respect to any information pertaining to the diagnosis, treatment or health of any enrollee or applicant, a prepaid limited health service organization shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the prepaid limited health service organization is entitled to claim.

C. In addition, any information provided to the commissioner that constitutes a trade secret, is privileged information, or is part of a department investigation or examination shall be held in confidence.

Section 27. Taxes

The same [tax/tax rates] provided for in [insert citation to state's health maintenance organization act] shall be imposed upon each prepaid limited health service organization, and the organization also shall be entitled to the same tax deductions, reductions, abatements and credits that health maintenance organizations are entitled to receive.

Drafting Note: The bracketed language in the first sentence of this section acknowledges that there may be different types of health maintenance organization taxes. Each state should review the applicability and appropriateness of extending any health maintenance organization taxes or tax rates that are in place to prepaid limited health service organizations. This review should consider: (1) the goals of, and reasoning for, the health maintenance organization taxes; (2) the significantly lower average per enrollee revenue of prepaid limited health service organizations as compared with that of health maintenance organizations; and (3) the applicability of equivalent health maintenance organization deductions, reductions, abatements and credits to prepaid limited health service organizations.

Section 28. Severability

If any section, term or provision of this Act shall be adjudged invalid for any reason by a court of competent jurisdiction, the judgment shall not affect, impair or invalidate any other section, term or provision of this Act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

Section 29. Regulations

The commissioner may, after notice and hearing, promulgate regulations to carry out the provisions of this Act.

Section 30. Effective Date

The effective date of this Act shall be [insert date].

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

1989 Proc. I 9, 24-25, 703, 755, 796-804 (adopted).
2007 Proc. 2nd Quarter (adopted guideline amendment