DEPARTMENT OF COMMUNITY HEALTH

MEDICAL SERVICES ADMINISTRATION

HEALTH MAINTENANCE ORGANIZATIONS

(By authority conferred on the department of public health and the insurance bureau by section 21025 of Act No. 368 of the Public Acts of 1978, as amended, being S333.21025 of the Michigan Compiled Laws)

PART 1. GENERAL PROVISIONS

R 325.6101 Definitions; A, B.

Rule 101. As used in these rules:

(a) "Act" means Act No. 368 of the Public Acts of 1978, as amended, being S333.1101 et seq. of the Michigan Compiled Laws, and known as the public health code.

(b) "Actuarially sound" means the ability and resources of the health maintenance organization to adequately deliver contractual health care services at its approved rate structure.

(c) "Authorized representative" means the individual designated in writing by the governing body to make application for the issuance of a license, to make amendments to the application, to provide the department and insurance bureau with all information necessary to make a determination in connection with the issuance of a license, and to enter into agreements with the department and the insurance bureau in connection with the issuance of a license.

(d) "Bargaining representative" means a representative designated for the purposes of collective bargaining under section 9(a) of the national labor relations act, as amended, 29 U.S.C. S151 et seq., under the railway labor act, as amended, 45 U.S.C. S151 et seq., or under other applicable state statute.

History: 1979 AC; 1988 AACS.

R 325.6105 Definitions; C, D.

Rule 105. As used in these rules:

(a) "Carrier" means a voluntary association, corporation, partnership, or other nongovernmental organization which is engaged in providing, paying for, or reimbursing all or part of the cost of, health benefits under group insurance policies and contracts or under medical or hospital service agreements in consideration of premiums or other periodic charges payable to the carrier.

(b) "Collective bargaining agreement" means an agreement entered into between an employer and the bargaining representative of its employees, and includes such agreements entered into on behalf of groups of employers with the bargaining representative of their employees under the national labor relations act, as amended, being 29 U.S.C. S151 et seq., under the railway labor act, as amended, being 45 U.S.C. S151 et seq., or under other applicable state statute.

(c) "Compensation" means salary, pay, or emolument given as compensation or wages for work done or services rendered, in cash or in kind, and includes the following:

(i) Salaries.
(ii) Wages.
(iii) Bonuses.
(iv) Commissions.
(v) Fees.
(vi) Tips.
(vii) Incentive payments.
(viii) Severance pay.
(ix) Vacation pay.
(x) Sick pay.

(d) "Designee" means any person or entity authorized to act on behalf of an employer to offer the option of membership in a licensed health maintenance organization to the employer's eligible employees.

(e) "Doing business" means an enterprise, activity, profession, or undertaking of any nature which is conducted or ordinarily conducted for profit, gain, or service by any person.

History: 1979 AC; 1988 AACS.

R 325.6110 Definitions; E, F.

Rule 110. As used in these rules:

(a) "Eligible employee" means an employee who meets the terms and conditions established by an employer or its designee to participate in a health benefits plan.

(b) "Emergency health service" means medical care rendered by affiliated or nonaffiliated providers, whether in or out of the service area, under unforeseen conditions requiring services necessary for the repair of accidental injury, relief of acute pain, elimination of acute infection, protection of the public health, and the amelioration of illness which, if not immediately diagnosed and treated, would result in physical impairment or loss of life. In an emergency, the principle of medical necessity, as determined by the health maintenance organization, prevails over all other considerations.

(c) "Employee" means any individual employed by an employer, whether on a full-time or part-time basis.

(d) "Employee's eligible dependent" means an eligible employee's dependent who meets the terms and conditions established by an employer or its designee to participate in a health benefits plan.

(e) "Employer" shall have the same meaning as defined in section 3(d) of the fair labor standards act of 1938, as amended, being 29 U.S.C. S203(d), or as defined in Act No. 154 of the Public Acts of 1964, as amended, being S408.381 et seq. of the Michigan Compiled Laws.

(f) "Employer-employee contract" means a legally enforceable agreement, other than a collective bargaining agreement, between an employer and its employees for the provision or payment of health benefits.

(g) "Freestanding outpatient facility" means a facility which is not otherwise licensed, in which health maintenance services are provided to enrollees, and which is owned or leased by, or otherwise under the direct management or operational control of, a health maintenance organization.

History: 1979 AC; 1988 AACS.

R 325.6115 Definitions; G to I.

Rule 115. As used in these rules:

(a) "Group enrollment period" means the period of not less than 10 working days each calendar year during which each eligible employee is given the opportunity to select among the alternatives included in a health benefits plan.

(b) "Health benefits" means an arrangement for the provision or payment of health services under the terms of a health benefits plan.

(c) "Health benefits contract" means an agreement between an employer, or its designee, and a carrier for the provision or payment of health benefits for eligible employees or for eligible employees and the employees' eligible dependents.

(d) "Health benefits plan" means an arrangement for the provision or payment of any of the primary or basic health services offered to eligible employees and the employees' eligible dependents by, or on behalf of, an employer.

(e) "Health care evaluation" means an organized approach to the review of a particular aspect of the program of care to assure that health care services are appropriate to patient needs and of appropriate quality and to assure that health care organization and administration support the timely and efficient provision of quality care.

(f) "Home health services" means those services provided in an enrollees home by a home health agency certified under title XVIII of the social security act, 42 U.S.C. SS1395 to 1395qq, or by health care personnel as prescribed or directed by the attending physician or other authority designated by the health maintenance organization.

(g) "Initial date of operation" means the date of licensure or the date of eligibility for health maintenance services by the initial enrollees of a licensed health maintenance organization, whichever is later.

History: 1979 AC; 1988 AACS.

R 325.6120 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6125 Definitions; M to P.

Rule 125. As used in these rules:

(a) "Medical audit" means the retrospective examination and evaluation of the clinical application of medical knowledge as revealed in the clinical patient record for the purposes of education, accountability, and quality assurance.

(b) "Nutritionist" or "dietitian" means a person who has a baccalaureate degree with major studies in food and nutrition and who is eligible for registration by the American dietetic association.

(c) "Out-of-area services" means a specifically authorized referral by the health maintenance organization on behalf of an enrollee or emergency care rendered to an enrollee in a geographic area beyond the health maintenance organization's defined service area under circumstances wherein it is not feasible for the enrollee to secure those services from the health maintenance organization.

(d) "Preventive health services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability, including any of the following:

(i) Immunizations.

(ii) Voluntary family planning.

(iii) Routine physical examinations.

(iv) Diagnostic screening procedures specific as to age or sex.

(v) Health education designed to heighten an individual's awareness and knowledge regarding the prevention of accidental injury, poisoning, disease, or disability caused or exacerbated by personal health practices.

(e) "Primary care center" means a facility which provides primary care physician services and which is owned or leased by, or contractually affiliated with, a health maintenance organization.

(f) "Primary care physician" means a licensed physician who is in general practice or a physician who is board-eligible or board-certified in 1 of the following specialties:

(i) Family practice.

(ii) Pediatrics.

(iii) Internal medicine.

(iv) Obstetrics and gynecology.

History: 1979 AC; 1988 AACS.

R 325.6130 Definitions; Q to U.

Rule 130. As used in these rules:

(a) "Quality assurance program" means the planned and systematic management actions which assure the consistent rendering of quality health care services through the use of monitoring techniques.

(b) "Service area" means a defined geographical area in which health maintenance services are generally available and readily accessible to enrollees and wherein health maintenance organizations may market their contracts to employers subject to section 21091 of the act.

(c) "To offer a health benefits plan" means to make participation in a health benefits plan available to eligible employees or to eligible employees and the employees' eligible dependents.

(d) "Utilization review" means prospective, concurrent, and retrospective review and analysis of data related to utilization of health care resources in terms of cost, effectiveness, efficiency, control, and quality.

History: 1979 AC; 1988 AACS.

R 325.6135 Terms defined in act.

Rule 135. Terms defined in the act have the same meanings when used in these rules.

History: 1988 AACS.

PART 2. STATE ADMINISTRATION

R 325.6201 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6205 License required.

Rule 205. A health maintenance organization or person shall not enter into a health maintenance contract without a valid license issued by the department, with the concurrence of the insurance bureau.

History: 1979 AC; 1988 AACS.

R 325.6210 Service areas.

Rule 210. (1) An applicant or potential applicant shall file with the department a description of the geographical area of service defined by the boundaries of political subdivisions, census tracts, or United States postal zip codes.

(2) The service area shall not exceed the geographical boundaries of a city or township which is more than a distance requiring 30 minutes of travel time to a primary care center and an affiliated acute care hospital, except in rural regions of counties with a population density of less than 25 people per square mile.

(3) The service area shall be subject to the approval of the department.

History: 1979 AC; 1988 AACS.

R 325.6215 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6220 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6225 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6230 Licensure; application forms.

Rule 230. Application for initial and renewal licensure shall be made on forms available from the department.

History: 1979 AC; 1988 AACS.

R 325.6235 Initial license; application; filing; withdrawal; amended application.

Rule 235. (1) An applicant for an initial license for a health maintenance organization shall file 2 copies of the application with the department and 2 copies with the insurance bureau.

(2) The application shall include the designation of the authorized representative.

(3) An application shall be deemed filed when all information necessary to properly process the application has been received by the department.

(4) On 1 occasion only, an applicant for an initial license may, upon written notice giving reasonable cause, request withdrawal of an application, and may resubmit an amended initial application within 90 days after the withdrawal without having to pay an additional fee. The amended application shall be processed as a new application. Additional information and data provided pursuant to a request by the department or insurance bureau after the application has been deemed properly filed is not an amendment to the initial application.

History: 1979 AC; 1988 AACS.

R 325.6240 Initial license; application; confirmation of receipt; issuance or denial of licensure; time; notice.

Rule 240. (1) The department and the insurance bureau shall, within 30 days of receipt, jointly confirm, by certified mail, the receipt of an application. The confirmation shall state the date the application is deemed filed or state the information necessary for the application to be deemed filed.

(2) The department and the insurance bureau shall issue or deny a license within 90 calendar days of the filing of the application, unless the applicant is notified 30 days before that the review has been extended an additional 30 days. The notice shall include the reason for the extension.

History: 1979 AC; 1988 AACS.

R 325.6245 Renewal license; application; filing.

Rule 245. An applicant for renewal of a health maintenance organization license shall file 2 copies of the renewal application with the department and 2 copies with the insurance bureau 90 days before the date the license is due to be renewed.

History: 1979 AC; 1988 AACS.

R 325.6250 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6255 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6260 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6265 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6270 License; notice of change in ownership or control.

Rule 270. The insurance bureau shall determine whether a change in the ownership or control of the health maintenance organization represents a major change which warrants action by the department or the insurance bureau, including requiring licensure of the changed entity, limitation of a license, or revocation of a license.

History: 1979 AC; 1988 AACS.

R 325.6275 Substantive information change; filing.

Rule 275. (1) The applicant or licensee shall file, within 30 calendar days, any substantive change in information submitted in the application pursuant to which a license, or renewal license has been or may be issued.

(2) A substantive information change is a change in any of the following:

(a) The officers of the corporation.

(b) The governing body.

(c) The controlling stock ownership.

(d) The health maintenance organization administration.

(e) The organization documents or bylaws.

(f) Contractual arrangements under which the health maintenance organization is managed.

History: 1979 AC; 1988 AACS.

R 325.6280 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6285 Posting license.

Rule 285. The current license or renewal license shall be posted in a conspicuous area of the health maintenance organization's principal office.

History: 1979 AC; 1988 AACS.

R 325.6290 Fees.

Rule 290. A fee shall be paid by a check made payable to: "State of Michigan" in the appropriate amount pursuant to section 21027(2) of the act. A fee shall not be refunded. For purposes of this rule, an evaluation or investigation includes a visitation or examination conducted by the insurance bureau pursuant to section 21025(1) of the act. The fees and expenses for insurance bureau visits or examinations shall be calculated in accordance with section 224(2) of Act No. 218 of the Public Acts of 1956, as amended, being S500.224(2) of the Michigan Compiled Laws.

History: 1979 AC; 1988 AACS.

PART 3. BUSINESS AND OPERATIONAL REQUIREMENTS

R 325.6301 Governing body; nomination and election procedures for adult enrollee representatives.

Rule 301. (1) A procedure shall be established to assure that the election of adult enrollee representatives to the governing body of a health maintenance organization shall take place within 12 months of the date of initial operation. A written description of the proposed procedure shall be submitted for approval of the insurance bureau not less than 90 days before the election.

(2) The nomination and election procedure for adult enrollee representatives shall meet all of the following minimum requirements:

(a) Provide an opportunity for the nomination of candidates for the governing body.

(b) Provide notice of the nomination and election procedures.

(c) Provide an opportunity for subscribers to vote for adult enrollee representatives through a balloting procedure.

(d) Provide subscribers with a listing of the governing body which identifies the adult enrollee representatives.

History: 1979 AC; 1988 AACS.

R 325.6305 Administrator; medical director; conflict of interest.

Rule 305. (1) A governing body shall employ an administrator or designate an executive officer who shall be responsible to the governing body for the daily conduct and operations of the health maintenance organization.

(2) The health maintenance organization shall assure the designation of a Michigan licensed physician as medical director, who shall be responsible for the medical aspects of the operation, including review of medical care provided, medical professional aspects of provider contracts, and other areas of responsibility as may be designated by the health maintenance organization.

(3) A governing body shall develop policies and procedures whereby full disclosure and discovery of any present or potential conflict of interest of any of the following shall be made known to the governing body within 30 working days of the date of discovery:

(a) Promoters.

(b) Incorporators.

(c) A partnership or association.

(d) Directors.

(e) Trustees.

(f) Members of the governing body.

(g) Officers of a health maintenance organization.

(h) Chief actuary.

(i) General counsel.

(j) Controller.

The policies and procedures shall be in accordance with section 21031(c) of the act and shall be filed and approved by the insurance bureau with the initial and renewal licensure application.

History: 1979 AC; 1988 AACS.

R 325.6310 Operation of health maintenance organization; written policies.

Rule 310. A governing body shall assure the adoption and implementation of written policies governing the operation of the health maintenance organization. Policies shall be dated and revised when indicated.

History: 1979 AC; 1988 AACS.

R 325.6315 Governing body meetings; quorum; record of proceedings; minutes.

Rule 315. (1) A governing body shall meet at least quarterly.

(2) A quorum for a governing body meeting shall be defined in the health maintenance organization bylaws.

(3) A governing body shall keep a permanent record of its proceedings, including all committees.

(4) The department or the insurance bureau may review all governing body and committee minutes and may attend governing body meetings to assess the governing body's compliance with these rules.

History: 1979 AC; 1988 AACS.

R 325.6320 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6325 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6330 Accounting procedures; financial and budgeting projections.

Rule 330. (1) A health maintenance organization shall implement and utilize accounting procedures acceptable to the insurance bureau, which may include chart of accounts, accounting procedures, and financial report forms.

(2) Financial and budgetary projections for the health maintenance organization shall be prepared in accordance with generally accepted accounting principles and procedures.

History: 1979 AC; 1988 AACS.

R 325.6335 Financial plan.

Rule 335. A health maintenance organization shall have a financial plan which is satisfactory to the insurance bureau. The financial plan shall meet all of the following requirements:

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

(b) Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the contract period for which payment has been made, including the continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge, which includes the payment to providers for services rendered or for coverage of projected operating expenses, for a designated period of time, based on such factors as the following:

(i) A financial guarantee contract insured by a surety bond issued by an independent insurer.

(ii) A reinsurance contract issued by an authorized and approved insurance company.

(iii) A contract which the health maintenance organization has with physicians, hospitals, clinics, or insurers.

(iv) A guaranteed line of credit.

(v) Projected fixed developmental costs.

(vi) Other factors which may affect the cash flow of the organization.

(c) Provide for an appropriate amount of working capital.

History: 1979 AC; 1988 AACS.

R 325.6340 Rates, copayments, or deductibles.

Rule 340. (1) A rate, copayment, or deductible charged by the health maintenance organization shall be filed and approved, before becoming effective, pursuant to sections 21063 and 21065 of the act.

(2) A health maintenance organization shall submit a written description of the methodology used to determine prepayment rates by category for approval by the insurance bureau.

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

(4) A change in a prepayment rate or nominal payment shall be submitted pursuant to sections 21063 and 21065 of the act and shall meet the criteria of section 21034(b) of the act. A schedule of rates for all subscriber contracts and riders may be required annually by the insurance bureau. All submissions shall note changes of rates previously filed or approved.

History: 1979 AC; 1988 AACS.

R 325.6345 Provider contracts.

Rule 345. (1) A health maintenance organization shall enter into contracts with providers through which health care services are usually provided to enrollees under the health maintenance organization plan.

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

(3) Affiliated provider contracts shall contain provisions to assure all of the following:

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

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

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

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

(5) Upon application for an initial license, a health maintenance organization shall submit standard contract formats proposed for use with its affiliated providers. Subsequent to licensure, substantive changes to contract formats and new contract formats shall be submitted to the insurance bureau for approval, with advice from the department, before use. The contract format or change shall be deemed approved 30 days after filing unless approved or disapproved within the 30 days. As used in this rule, "substantive changes to contract formats" means a change to a provider contract which alters the method of payment to a provider, alters the risk assumed by each party to the contract, or affects a provision required by statute or these rules.

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

History: 1979 AC; 1988 AACS.

R 325.6350 Reinsurance contracts or amendments.

Rule 350. (1) A health maintenance organization shall obtain a reinsurance contract or establish a plan of self-insurance with approval of the insurance bureau as may be necessary to ensure solvency or provider coverage for undue risk. A reinsurance contract shall be with a company which meets the requirements for conducting business in Michigan.

(2) A reinsurance contract or amendment shall be filed with the insurance bureau for approval within 30 days of the finalization of a contract or amendment.

(3) A reinsurance contract and amendment shall be deemed approved after 30 days unless disapproved in writing before the thirtieth day of receipt by the insurance bureau.

(4) A reinsurance contract or amendment shall clearly state all services to be received by the health maintenance organization, including actuarial services and marketing services.

History: 1979 AC; 1988 AACS.

R 325.6355 Insurance against loss; self-insurance arrangements.

Rule 355. (1) A health maintenance organization shall maintain insurance coverage to protect the health maintenance organization from excessive loss, which may include, but is not limited to, fire, theft, general liability, and malpractice insurance.

(2) Coverage against loss shall be subject to review by the insurance bureau.

(3) A proposed self-insurance arrangement shall be filed with and approved by the insurance bureau before becoming effective.

History: 1979 AC; 1988 AACS.

R 325.6360 Verification of eligibility.

Rule 360. (1) A health maintenance organization shall establish a system, to verify an enrollee's eligibility for services. The system shall be approved by the insurance bureau.

(2) A person presenting appropriate identification of membership shall not be denied services because of a provider's inability to verify eligibility.

History: 1979 AC; 1988 AACS.

R 325.6365 Grievance procedures.

Rule 365. (1) A health maintenance organization shall establish an internal enrollee grievance procedure for approval by the insurance bureau, which, at a minimum, does all of the following:

(a) Provides for a designated person responsible for administering the grievance system.

(b) Provides a designated person or phone number for receiving complaints.

(c) Ensures full investigation of a complaint.

(d) Provides for timely notification to the enrollee as to the progress of an investigation.

(e) Provides an enrollee the right to appear before the board of directors or designated committee to present a grievance.

(f) Provides for notification to the enrollee of the results of the health maintenance organization's investigation and for advisement of the enrollee's right to review of the grievance by the advisory commission.

(g) Provides summary data on the number and types of complaints filed.

(h) Provides for periodic management and governing body review of the data to assure that appropriate actions have been taken.

(2) Copies of all complaints and responses shall be available at the principal office of the health maintenance organization for inspection by the insurance bureau or the Department for 2 years following the year the complaint was filed.

History: 1979 AC; 1988 AACS.

PART 4. SUBSCRIBER CONTRACTS, COVERAGE, AND RELATED REQUIREMENTS

R 325.6401 Health maintenance contracts; riders and rates; filing; nominal payments and deductibles.

Rule 401. (1) A proposed health maintenance contract, or riders for subscribers, and the rate shall be filed for approval. A contract and rate developed and proposed subsequent to licensure shall be filed with the insurance bureau pursuant to section 21063 of the act.

(2) A proposed change in a contract, rider, or a rate shall be filed with the insurance bureau pursuant to sections 21063 and 21065 of the act.

(3) For purposes of this part, nominal payments and deductibles in a health maintenance contract shall not exceed 50% of the reasonable charge of the service.

History: 1979 AC; 1988 AACS.

R 325.6405 Health maintenance contracts; contents.

Rule 405. (1) A health maintenance contract shall include any approved riders, amendments, and the enrollment application.

(2) A health maintenance contract shall include, at a minimum, all of the following:

(a) Name and address of the organization.

(b) Definitions of terms subject to interpretation.

(c) The effective date and duration of coverage.

(d) The conditions of eligibility.

(e) A statement of responsibility for payments.

(f) A description of specific benefits and services available under the contract within the service area, with respective copayments.

(g) A description of emergency and out-of-area services.

(h) A specific description of any limitation, exclusion, and exception, including any preexisting condition limitation, grouped together with captions in boldface type.

(i) Covenants which address confidentiality, an enrollee's right to choose or change the primary care physician or other providers, availability and accessibility of services, and any rights of the enrollee to inspect and review his or her medical records.

(j) Covenants of the subscriber shall address all of the following subjects:

(i) Timely payment.

(ii) Nonassignment of benefits.

(iii) Truth in application and statements.

(iv) Notification of change in address.

(v) Theft of membership identification.

(k) A statement of responsibilities and rights regarding the grievance procedure.

(l) A statement regarding subrogation and coordination of benefits provisions, including any responsibility of the enrollee to cooperate.

(m) A statement regarding conversion rights.

(n) Provisions for adding new family members or other acquired dependents, including conversion of individual contracts to family contracts and family contracts to individual contracts, and the time constraints imposed.

(o) Provisions for grace periods for late payment.

(p) A description of any specific terms under which the health maintenance organization or the subscriber can terminate the contract.

(q) A statement of the nonassignability of the contract.

History: 1979 AC; 1988 AACS.

R 325.6410 Health maintenance contracts; cancellation; generally.

Rule 410. (1) A non-group subscriber, in addition to other rights available to revoke an offer, may cancel a health maintenance contract within 72 hours after signing. Any deposit or prepayment made shall be refunded within 30 days of receipt of the notice of cancellation. A non-group subscriber shall be responsible for payment of reasonable fees for any services received during the 72 hours. Fees may be deducted from the deposit or prepayment before the refund is made.

(2) Cancellation shall occur when written notice of cancellation is mailed or hand-delivered to the organization or its agent or representative.

(3) Notice of cancellation shall be sufficient if it indicates the intention of the person not to be bound by the contract or application.

(4) The right of cancellation shall appear in boldface type on the same page the individual subscriber signs to bind the contract.

History: 1979 AC; 1988 AACS.

R 325.6415 Health maintenance contracts; conditions of cancellation; enrollee's rights and options; effect of continued prepayment during appeal.

Rule 415. (1) A health maintenance contract shall clearly delineate all conditions under which the health maintenance organization may cancel coverage for an enrollee.

(2) A health maintenance contract for non-group subscribers shall specify an enrollee's rights and options in the case of a proposed amendment or change in the contract or the rate charged, and such contract shall be in accord with section 21065 of the act and subrule (3) of this rule.

(3) Continued prepayment by the subscriber during the period of appeal, and while an appeal is in progress, shall not be deemed to constitute acceptance of the proposed amendment or rate change.

History: 1979 AC; 1988 AACS.

R 325.6420 Hearing on termination of coverage.

Rule 420. (1) When an enrollee is terminated, a hearing may be requested before the health facilities and agencies advisory commission after exhaustion of the enrollee's remedies under the health maintenance organization's grievance procedure.

(2) Upon receipt of a request for a hearing, the department shall, in conjunction with the chairperson of the health facilities and agencies advisory commission, do both of the following:

(a) Advise the appellant, within 20 days after receipt of the appeal, as to the date, time, and place of the scheduled hearing.

(b) Notify the insurance bureau, the health maintenance organization, and the enrollee of the time and place of the hearing.

(3) The burden of proof shall be upon the health maintenance organization to show that it has good cause for cancellation; however, when the cancellation is for non-payment of charges, the burden of proof shall be upon the enrollee to show a tender of payment before the date of cancellation.

(4) Within 30 days after the conclusion of the hearing, the health facilities and agencies advisory commission shall notify both parties, in writing, of its decision.

History: 1979 AC; 1988 AACS.

R 325.6425 Identification as evidence of enrollment.

Rule 425. (1) A subscriber shall receive identification as evidence of enrollment under a health maintenance contract.

(2) A health maintenance organization shall cause the mailing address and telephone number of the plan to be inscribed on, or otherwise affixed to, the identification.

(3) The identification shall be accepted as evidence of enrollment by all affiliated providers unless ineligibility is otherwise verified.

History: 1979 AC; 1988 AACS.

R 325.6430 Information to which subscriber is entitled; filing; changes.

Rule 430. (1) In addition to the health maintenance contract and identification, a subscriber shall receive, at the time of enrollment, or be mailed or delivered, within 30 days of the effective date of coverage, all of the following:

(a) Addresses, telephone numbers, and hours of affiliated primary care facilities, including the names, addresses, and telephone numbers of ambulances, hospitals, other facilities, and answering services with which the health maintenance organization has arrangements for emergency service.

(b) Delineation of services available.

(c) Instructions on choosing a primary care site and physician and how to obtain services.

(d) Procedures for appointments and urgent conditions.

(e) Procedures to be followed in cases of emergency or out-of-area services.

(f) The telephone number and address of where, and clear instructions of how, the enrollee can file complaints or grievances.

(2) The information shall be filed before licensure.

History: 1979 AC; 1988 AACS.

PART 5. MARKETING AND ENROLLMENT

R 325.6501 Marketing and enrollment plan.

Rule 501. (1) A health maintenance organization shall, at the time of application for initial state licensure, submit a marketing and enrollment plan to the department for approval by the insurance bureau.

(2) The plan shall be in accord with the act and these rules and shall include all of the following:

(a) A description of the data, information, methodology, and assumptions used in projecting enrollment levels by enrollment category, including, at a minimum, a 3-year projection for enrollment.

(b) A description of the proposed marketing and enrollment methods.

(c) All of the following information pertaining to marketing and enrollment:

(i) The type and number of marketing and enrollment people, including internal staff.

(ii) Proposed external solicitors, agents, or other enrollment representatives.

(iii) Insurance company or other third-party consultation or services in relation to marketing and enrollment.

(iv) Designation of the administrator primarily responsible for marketing and enrollment.

(d) A description of the methods and mechanisms employed to ensure accountability of enrollment representatives.

(e) All proposed promotional, advertising, and informational materials, including all of the following:

(i) Descriptive literature.

(ii) Form letters.

(iii) Advertising copy.

(iv) Scripts and illustrations for radio, television, or films.

(f) A description of the enrollment process, including all of the following:

(i) The application or related forms.

(ii) Application procedures.

(iii) Processing steps.

(iv) A statement of the projected time frame for processing applications.

History: 1979 AC; 1988 AACS.

R 325.6505 Advertising; solicitation materials.

Rule 505. (1) Advertising, solicitation materials, and similar copy for public or enrollee information shall be truthful and not misleading in fact or implication.

(2) A word or phrase, the meaning of which is unclear or the understanding of which depends upon familiarity with technical terminology, shall not be used.

(3) A health maintenance organization shall maintain, at its principal office, a complete file containing all of the following printed, published, or prepared materials:

(a) Advertising brochures.

(b) Form letters of solicitation.

(c) Evidences of coverage, certificate, agreement, or contract.

(d) Copies of all radio and television forms disseminated in this or any other state. The file shall be maintained for a period of not less than 2 years.

History: 1979 AC; 1988 AACS.

R 325.6510 Agents, solicitors, and enrollment representatives.

Rule 510. (1) An agent, solicitor, or other enrollment representative of a health maintenance organization engaged in soliciting or enrolling subscribers is bound by these rules, and the health maintenance organization is responsible for the acts of the representatives in soliciting and enrolling subscribers.

(2) The insurance bureau may require full disclosure of all sales arrangements, including methods of payment to sales representatives, and may review such arrangements to ensure compliance with the act.

History: 1979 AC; 1988 AACS.

R 325.6515 Rescinded.

History: 1979 AC; 1988 AACS.

PART 6. STANDARDS FOR SERVICES, STAFFING, QUALITY ASSURANCE, AND UTILIZATION REVIEW

R 325.6601 Quality assurance program; conduct; contents.

Rule 601. A health maintenance organization shall have formal organizational arrangements for an ongoing quality assurance program approved by the department. At a minimum, the program shall include all of the following:

(a) A statement of the role and responsibilities of the medical director.

(b) An organizational structure created for the purpose of monitoring, reviewing, and evaluating the quality of health care services provided and the appropriateness of health care resources utilized.

(c) Standards and criteria against which the quality of health services can be assessed.

(d) Mechanisms assuring that data collected is based on the total enrolled population or on a valid sample.

(e) Arrangements for routine reporting of results of quality assurance program activities to the governing body, administration, providers, and the department.

(f) Provisions for initiating corrective actions where deficiencies in individual provider or organizational performance are identified.

(g) Provisions for reevaluating previously identified problem areas in which corrective action has been initiated.

History: 1979 AC; 1988 AACS.

R 325.6605 Review procedure for inpatient health facility utilization.

Rule 605. The health maintenance organization shall assure an internal review procedure for inpatient health facility utilization, which shall contain provisions for all of the following:

(a) Prior plan authorization of elective admissions to inpatient health facilities.

(b) Arrangements for the ongoing collection and review of utilization data.

(c) Establishment of concurrent review for inpatient health facility admissions, which may include assignment of estimated length of stays based upon published norms specific to admitting diagnosis, adjusted for age and applicable operative status, and developed by recognized abstracting services or third-party payors.

(d) The role of the medical director in concurrent and retrospective analyses of inpatient stays which exceed recognized norms.

History: 1979 AC; 1988 AACS.

R 325.6610 Medical audits; clinical indexing procedures.

Rule 610. (1) The health maintenance organization shall conduct, at least semiannually, medical audits for the following purposes:

(a) Assuring the adequacy, maintenance, and documentation of clinical patient data in the clinical records.

(b) Evaluating continuity and coordination of patient care.

(c) Assessing the quality of health and medical care provided.

(2) The medical record system shall include a procedure for the retrieval of clinical patient records by diagnosis or category of service.

History: 1979 AC; 1988 AACS.

R 325.6615 Health care evaluations.

Rule 615. (1) The health maintenance organization shall assure that health care evaluations are conducted to promote the effective and efficient use of available health facilities, services, and personnel consistent with enrollee needs and professionally recognized standards of health care, including nursing care.

(2) The evaluations shall emphasize identification and analysis of patterns of patient care and recommend appropriate changes for maintaining quality patient care as well as effective and efficient use of services.

(3) The health care evaluations shall utilize criteria and standards established by the members of the quality assurance program.

(4) At least 1 evaluation shall be completed each year.

History: 1979 AC; 1988 AACS.

R 325.6620 Quality assurance program; minutes and records.

Rule 620. (1) Minutes and records of quality assurance program activity shall be maintained for a period of 3 years.

(2) The minutes and records shall be available to the department for purposes of examination and review.

History: 1979 AC; 1988 AACS.

R 325.6625 Diagnostic and therapeutic radiology services; pharmacy services; clinical pharmacy services; nutrition and dietetic services.

Rule 625. (1) Diagnostic and therapeutic radiology services shall be provided under the direction of a licensed physician. Radiographic interpretation services shall be under the direction of a board-certified or board-eligible radiologist. Radiographic x-ray equipment shall be registered with the division of radiological health of the department, with evidence of compliance with the ionizing radiation rules of the department.

(2) Pharmacy services or clinical pharmacy services, when provided, shall be under the control and direction of a licensed pharmacist. Pharmacy services shall be consistent with standard professional practice.

(3) Nutrition and dietetic services, when identified as a service, shall be provided by, or with the consultation of, a professionally qualified nutritionist or dietitian and shall consist of nutrition education and counseling.

History: 1979 AC; 1988 AACS.

R 325.6630 Preventive health services.

Rule 630. In support of the provision of health services, a health maintenance organization shall make available to its members the following:

(a) Screening or physical examination specific as to age or sex.
(b) Preventive health education services and education in the appropriate use of health services and in the contribution each member can make to the maintenance of his own health.
(c) Information about the health maintenance organization's services.

History: 1979 AC.

R 325.6635 Professional staff.
Rule 635. (1) A health maintenance organization shall assure the maintenance of professional staff sufficient to meet the needs of its membership. Disclosure of the ratio of full-time equivalent physicians and other health professionals to prepaid enrollees shall be made to the department.
(2) The specialty mix of physicians shall be consistent with the projected health needs of the population enrolled or to be enrolled, the experienced need of like organizations within and without the state, and accepted standards consistent with the practice of quality medicine.
Physicians identified as specialists shall be certified by the appropriate specialty boards or shall be qualified to take the examination offered by the specialty boards.
(3) Each health maintenance organization shall have available or on call not less than 2 licensed physicians to ensure the provision of adequate patient care 24 hours a day.
(4) A health maintenance organization shall assure that all physicians and other health professionals engaged in the provision of health services to enrollees are currently licensed or certified by the state to practice their respective professions. A health professional who provides services in an adjacent state shall be licensed, if required, by his or her resident state.

History: 1979 AC; 1988 AACS.

R 325.6640 Nonprofessional staff.
Rule 640. Nonprofessional health care staff shall perform their health care functions under the direction of a licensed physician or appropriate health professional affiliated with the health maintenance organization.

History: 1979 AC.

PART 7. FACILITY STANDARDS

R 325.6701 Utilization of licensed or certified facilities; requirements as to laboratories exempt from licensure; x-ray facilities and equipment.
Rule 701. (1) A health maintenance organization shall utilize health facilities required by the act to be licensed by the department to operate.
(2) A laboratory exempt from licensure under section 20507 of the act may be used by a primary care physician or a group of not more than 5 primary care physicians which owns and operates the laboratory only for the patients of the physician or physicians of a group. The laboratory shall be directed by a physician licensed to practice medicine or osteopathy in this state and the laboratory shall conform to performance evaluation and quality control procedures contained in the health maintenance organization quality assurance program approved by the department.
(3) X-ray facilities and equipment shall be in compliance with existing codes, standards, and law.

History: 1979 AC; 1988 AACS.

R 325.6702 Physician's office exemption.
Rule 702. A physician's office facility of an affiliated physician having a contractual relationship with a health maintenance organization for not less than 2 years before acquisition by the health maintenance

organization is exempt from the definition of a freestanding outpatient facility if the office facility is certified to be in compliance with applicable local codes.

History: 1988 AACS.

R 325.6705 Rescinded.

History: 1979 AC; 1988 AACS; 1991 AACS.

R 325.6710 Facility maintenance.

Rule 710. The premises of the health maintenance organization's facilities, including those of affiliated providers, shall be maintained in a safe and sanitary condition in a manner consistent with the public health and welfare and shall be safely constructed and be free from hazards to patients, personnel, and visitors.

History: 1979 AC; 1988 AACS; 1991 AACS.

R 325.6715 Exterior requirements for freestanding outpatient facility.

Rule 715. The exterior of a freestanding outpatient facility shall have both of the following:

(a) At least 1 entrance which provides safe and easy access for the physically handicapped and which complies with the provisions of Act No. 230 of the Public Acts of 1972, as amended, being S125.1501 et seq. of the Michigan Compiled Laws.

(b) Sufficient lighting of ramps and stairs to assure the safety of persons using the facility.

History: 1979 AC; 1988 AACS.

R 325.6720 Lighting; ventilation; corridors, hallways, passageways, and doorways; floors, walls, and ceilings; freestanding outpatient facility.

Rule 720. (1) Each area of a freestanding outpatient facility shall be provided with lighting adequate for the use to be made of the location and in accord with generally recognized lighting standards.

(2) Each area of the facility shall be provided with a type and amount of ventilation commensurate with its use to minimize the occurrence of transmissible disease, to control odors, and to contribute to the comfort of patients and personnel.

(3) Corridors, hallways, passageways, and doorways shall be kept free from obstruction at all times.

(4) Floors, walls, and ceilings shall be covered and finished in a manner that will permit the maintenance of a sanitary environment.

(5) Floor and wall penetration by pipes, ducts, and conduits shall be tightly sealed to minimize the entry of rodents and insects. Joints of structural elements shall be similarly sealed.

History: 1979 AC; 1988 AACS.

R 325.6725 Required areas and rooms in freestanding outpatient facility.

Rule 725. (1) Adequate space shall be provided for reception and waiting in a freestanding outpatient facility.

(2) One or more rooms equipped with water closets and lavatory facilities shall be accessible for persons in the waiting and reception area.

(3) All patient areas of the facility shall provide for the privacy and dignity of the patient during interview, examination, and treatment.

History: 1979 AC; 1988 AACS.

R 325.6730 Sinks, sterilization equipment, and storage space in freestanding outpatient facility.

Rule 730. The following provisions apply to freestanding outpatient facilities:

(a) A sink with a gooseneck outlet shall be available in, or adjacent to, examination and procedure rooms.

(b) Sterilization equipment shall be provided to process all medical supplies which require sterilization between each use. Equipment shall have sufficient capacity to accommodate the work load of the facility. Adequate space for sterilization equipment shall be provided.

(c) Storage space shall be available for the storage of clean linen, equipment, and supplies.

(d) A janitor's closet with service sink shall be available.

History: 1979 AC; 1988 AACS.

R 325.6735 Examination rooms in freestanding outpatient facility.

Rule 735. In freestanding outpatient facilities, examination rooms shall be provided which are adequate to meet the volume of work to be accomplished, and each room shall provide a minimum of 70 square feet of usable floor space. In new construction or renovations of freestanding outpatient facilities, 80 square feet of usable floor space shall be provided.

History: 1979 AC; 1988 AACS.

R 325.6740 Water system connection for freestanding outpatient facility.

Rule 740. (1) A freestanding outpatient facility located in an area served by a public water system shall connect to and use the system.

(2) When a public water system is not available, the location and construction of a well and the operation of a private water system shall comply with the applicable provisions of Act No. 399 of the Public Acts of 1976, being S325.1001 et seq. of the Michigan Compiled Laws.

(3) There shall be no cross-connections between water systems that are safe for human consumption and those that are, or may become, unsafe for human consumption.

(4) The minimum water pressure available to each plumbing fixture shall be more than 20 pounds per square inch.

(5) The plumbing system shall supply an adequate amount of hot water at all times to meet the needs of the various service areas. Hot water accessible to the public shall be tempered to a range of 110 to 125 degrees Fahrenheit.

History: 1979 AC; 1988 AACS.

R 325.6745 Liquid waste disposal in freestanding outpatient facility.

Rule 745. (1) Liquid wastes from a freestanding outpatient facility shall be discharged into a public sanitary sewage system when such a system is available.

(2) When a public sanitary sewage system is not available and a private liquid wastewater disposal system is used, the type, size, construction, and alteration of, or major repair to, the system shall be approved by the department or appropriate local health agency.

(3) The wastewater disposal system shall be maintained in a sanitary manner.

History: 1979 AC; 1988 AACS.

R 325.6750 Solid waste disposal in freestanding outpatient facility.

Rule 750. (1) The collection, storage, and disposal of solid wastes, refuse, and dressings in a freestanding outpatient facility shall be accomplished in a safe and sanitary manner to minimize the danger of disease transmission and to avoid creating a public nuisance or a breeding place for insects and rodents.

(2) Suitable containers for refuse, dressings, and other solid wastes shall be provided, emptied at frequent intervals, and maintained in a clean and sanitary condition.
(3) Needles, dressings, bandages, and similar materials shall be disposed of in a safe manner.

History: 1979 AC; 1988 AACS.

R 325.6755 Storage of hazardous and toxic materials; storage area; supplies of linens, dressings, and similar items; drugs; freestanding outpatient facility.
Rule 755. All of the following provisions apply to freestanding outpatient facilities:
(a) Hazardous and toxic materials shall be stored in a safe manner.
(b) A storage area shall be provided and shall have the space necessary to meet the storage needs of the facility.
(c) Supplies of gowns, drapes, towels, gloves, dressings, bandages, and similar items shall be maintained in sufficient quantities for regular use.
(d) The drug storage, dispensing, and administration system shall comply with applicable state laws and administrative rules.

History: 1979 AC; 1988 AACS.

R 325.6760 Rescinded.

History: 1979 AC; 1988 AACS; 1991 AACS.

R 325.6765 Rescinded.

History: 1979 AC; 1988 AACS; 1991 AACS.

R 325.6770 Rescinded.

History: 1979 AC; 1988 AACS; 1991 AACS.

R 325.6775 Rescinded.

History: 1988 AACS; 1991 AACS.

R 325.6780 New construction of freestanding outpatient facility housing radiology equipment.
Rule 780. All of the following provisions apply to the new construction of freestanding outpatient facilities housing radiology equipment:

(a) Radiographic rooms shall be a separate and distinct area from film processing.
(b) If fluoroscopic procedures are part of the program, toilet rooms with hand-washing facilities shall be directly accessible from each fluoroscopy room without entering a general corridor.
(c) Dressing areas, as required by the services provided, shall have convenient access to toilets.

History: 1988 AACS.

R 325.6785 New construction of freestanding outpatient facility; specimen collection area.
Rule 785. Both of the following provisions apply to the new construction of freestanding outpatient facilities:

(a) Urine collection rooms shall be equipped with a water closet and lavatory.
(b) Blood collection areas shall have space for a chair, work counter, and adjacent hand-washing facilities.

History: 1988 AACS.

R 325.6790 New construction of freestanding outpatient facility; elevator; drinking fountain; door width; procedure room.
Rule 790. All of the following provisions apply to the new construction of freestanding outpatient facilities:
(a) An elevator shall be a necessary building component where patient care is provided at different floor levels. The cab size of the elevator shall be sufficient to accommodate a stretcher and attendant.
(b) An approved type of public drinking fountain shall be provided at each floor level of patient care.
(c) Doors shall have a minimum width of 34 inches.
(d) Procedure rooms for minor surgical and casting procedures shall have a minimum floor area of 120 square feet.

History: 1988 AACS.

R 325.6795 New construction of freestanding outpatient facility; parking.
Rule 795. All of the following provisions apply to the new construction of freestanding outpatient facilities:
(a) In the absence of a formal parking study approved by the appropriate local agency, patient parking for outpatient facilities shall be provided at the rate of 2 spaces for each treatment room and each examination room.
(b) Sufficient parking spaces shall be available to accommodate the maximum number of staff at any given time.
(c) On-street parking, if available, may be considered as meeting a portion of the parking space requirement.

History: 1988 AACS.

PART 8. ENROLLEE CLINICAL RECORDS; REPORTS AND INSPECTIONS

R 325.6801 Clinical patient records; medical records service; record administrator or technician.
Rule 801. (1) The health maintenance organization shall assure the maintenance of a clinical patient record in accordance with accepted professional standards and practices.
(2) A clinical patient record of health maintenance services provided on an inpatient basis in licensed health facilities shall be the responsibility of the inpatient facility and shall be available to the health maintenance organization and to the department or its authorized representative for purposes of examination, investigation, and review.
(3) The medical records service shall have sufficient staff, facilities, and equipment to maintain clinical records that are complete and accurately documented, readily accessible, and organized so as to facilitate the retrieval and compilation of information.
(4) A person in each primary care site of the health maintenance organization shall be designated as the person with the responsibility for assuring the records are maintained, completed, and preserved. The designated individual shall, if not already a registered medical record administrator or accredited record technician, be trained by, and shall receive consultation from, a registered record administrator or an accredited record technician.

History: 1979 AC; 1988 AACS.

R 325.6805 Clinical patient records; contents; entries; organization; reports.

Rule 805. (1) The health maintenance organization shall assure the maintenance of a unit clinical record and, to the extent possible, shall assure that each person receiving services shall have an initial medical evaluation as outlined in subdivision (b) of this subrule. The record shall be current and shall include all of the following:

(a) An identification sheet, which includes all of the following information pertaining to the enrollee:

(i) Name.

(ii) Date of birth or age.

(iii) Sex.

(iv) Name of next of kin, a responsible person, or a person to contact in case of emergency.

(b) An initial medical evaluation, which includes all of the following:

(i) Past medical history.

(ii) Personal history.

(iii) Family history.

(iv) Documentation of the results of a baseline physical examination or age/sex-specific screening.

(c) Laboratory and radiology reports.

(d) Consultation reports.

(e) Copies of discharge summaries from inpatient health facilities.

(f) Copies of reports of services by affiliated and nonaffiliated providers.

(g) Physicians' and other health professionals' clinical or progress notes documenting the reason for each encounter or visit provided to the enrollee.

(h) Drug reactions.

(i) Allergies.

(j) Immunization record.

(2) An entry in a clinical patient record shall be dated and signed by the provider of the service.

(3) The clinical patient record shall be organized and maintained in a manner that facilitates review and reporting of clinical information.

(4) A report of external referral or inpatient service shall be entered into the clinical patient record within 60 calendar days following the completion of services by the provider.

History: 1979 AC; 1988 AACS.

R 325.6810 Clinical patient records; confidentiality; disclosure; availability; storage and preservation.

Rule 810. (1) Information contained in the clinical patient record shall be treated as confidential, shall be disclosed only to authorized persons, and shall be available at all times to the department for purposes of examination and review.

(2) An inactive record shall be safely stored and preserved electronically or as an original record or microfilm. The health maintenance organization shall adopt a policy concerning the length of time and provisions for the retention of inactive clinical records, which shall include a contingency plan for the retention of existing records in the event of cessation of operations.

History: 1979 AC; 1988 AACS.

R 325.6815 Annual report; contents; submission of cumulative data.

Rule 815. (1) In addition to the requirements of section 21083 of the act, the annual report shall include all of the following:

(a) Summary statistics relative to the enrolled population, including all of the following:

(i) Distribution by age and sex.

(ii) Method of payment.

(iii) Contract type.

(iv) Family size.

(b) Aggregate data of service utilization, expressed as a ratio of total encounters by service to the number of enrollee months.

(c) Descriptive summaries of health care evaluations undertaken and completed during the year.

(2) The following summary statistics shall be reported quarterly:

(a) Distribution by age and sex.
(b) Aggregate data of service utilization.

History: 1979 AC; 1988 AACS.

R 325.6820 Rescinded.

History: 1979 AC; 1988 AACS.

R 325.6825 Annual financial report; periodic interim reports.

Rule 825. (1) The annual financial report of the health maintenance organization shall be in accordance with section 21083 of the act and shall contain information and be prepared on forms prescribed by the insurance bureau.

(2) The insurance bureau shall require interim financial reports from health maintenance organizations when the bureau determines that the financial condition warrants monitoring under section 21023(3) of the act.

History: 1979 AC; 1988 AACS.

R 325.6830 Periodic examination of health care services; financial examinations.

Rule 830. (1) Periodic examination by the department regarding the quality of health care services being provided by the health maintenance organization shall include, but not be limited to, all of the following:

(a) Evaluation of results of the quality assurance program and utilization review activities and, if applicable, external review process.
(b) Evaluation of the availability, accessibility, and continuity of services.
(c) Inspection and evaluation of the clinical record system.
(d) An evaluation of compliance with these rules and the act.

(2) The insurance bureau shall conduct a financial examination of the health maintenance organization in accordance with section 21025 of the act.

History: 1979 AC; 1988 AACS.

R 325.6835 Grievance reports.

Rule 835. An annual report, in the form prescribed, shall be submitted to the department and contain a compilation and analysis of the grievances filed and their dispositions.

History: 1979 AC; 1988 AACS.

R 325.6840 Annual report to subscribers.

Rule 840. The annual report to subscribers shall be in accord with the act and shall include a summary of the most recent annual financial statement, the annual enrollment figures, a summary of current activities of the health maintenance organization, the current members of the governing body with identification of the subscriber representatives, and the procedures for enrollee contact with the governing body members.

History: 1979 AC.

PART 9. HEALTH MAINTENANCE ORGANIZATION INCLUSION IN HEALTH BENEFIT PLANS

R 325.6901 Request for inclusion in employer's health benefits plan.

Rule 901. (1) A request for inclusion in an employer's health benefits plan by a health maintenance organization shall be received by the employer not less than 180 days before the expiration or renewal date of a health benefits contract or employer-employee contract and not less than 90 days before the expiration date of a collective bargaining agreement, unless otherwise agreed to by the health maintenance organization and the employer or its designee.

(2) A health benefits contract with a carrier that has no fixed term or has a term of more than 1 year shall be treated as renewable on the anniversary date of the contract.

(3) For an employer who is self-insured, the budget year shall be considered the term of the existing contract.

(4) An employer with a collective bargaining agreement that is automatically renewable and without a fixed term, or is for a fixed term but has provisions for periodically changing the wages, hours, or conditions of employment, shall be treated as renewable on the anniversary date of the collective bargaining agreement if it has no fixed term, or at such other times, not less than annually, as may be provided by the agreement for discussion of changes in its provision.

(5) The request for inclusion in an employer's health benefits plan by a health maintenance organization shall comply with all of the following provisions:

(a) Be in writing directed to the employer at the site to be solicited or to the employer's designee specifying the designated sites for solicitation.

(b) Provide a current financial report.

(c) Describe the area served by the health maintenance organization or the proposed service area.

(d) Describe the location of facilities where health services shall be available.

(e) Include proposed contracts to be entered into between the health maintenance organization and the employer or the employer's designee.

(f) Include sample copies of marketing brochures and membership literature.

(g) State the prepayment rate for primary and basic health services for various categories of membership.

(h) Identify the staff and ownership of the health maintenance organization and facilities providing health maintenance services for the organization.

(i) State the health maintenance organization's capacity to enroll new members and the likelihood of any future limitations on enrollment.

History: 1979 AC; 1988 AACS.

R 325.6905 Option of membership in health maintenance organization generally.

Rule 905. (1) An employer is not required to include, in a health benefits plan offered to eligible employees, the option of membership in a health maintenance organization which initially requested inclusion in the health benefits plan in a timely manner, but may select other health maintenance organizations that may have not made a timely request, but wish to be included. This selection does not release the employer from the obligation to offer the option of membership in any 1 of not less than 2 health maintenance organizations where they exist in the service area.

(2) The employer may include, in the health benefits plan offered to employees, the option of membership in additional health maintenance organizations as the employer may decide to include; however, if the employer is subject to section 8 of the national labor relations act, 29 U.S.C. S158, or other applicable statute, the selection among competing health maintenance organizations shall be made in accordance with the collective bargaining process of the act.

History: 1979 AC; 1988 AACS.

R 325.6910 Option of membership in health maintenance organization offer to employee represented by collective bargaining representative; employee eligibility.

Rule 910. (1) For an employee represented by a collective bargaining representative, the offer of the health maintenance organization option is subject to the collective bargaining process.

(2) For an employee not represented by a collective bargaining representative, the offer of the health maintenance organization option shall be made directly by the employer.

(3) Employee eligibility for participation in a health benefits plan is established under the employer's existing procedures.

History: 1979 AC; 1988 AACS.

R 325.6915 Group enrollment period; affirmative written selection; coordination of benefits.

Rule 915. (1) An employer or designee including the option of membership in a health maintenance organization as part of the health benefits plan offered to eligible employees shall provide a group enrollment period of at least 10 working days each calendar year during which eligible employees may enroll in a health maintenance organization or may transfer from a health maintenance organization to any other alternative without application of a waiting period for pre-existing conditions.

(2) During the group enrollment period in which the alternative of membership in a licensed health maintenance organization is offered to a group of employees for the first time, the health benefits plan alternative shall be presented to each eligible employee, with the requirement that an affirmative written selection shall be made among the different alternatives included in the health benefits plan. In subsequent group enrollment periods, when selection among alternatives is available, written selection is required only when the eligible employee elects to transfer from one alternative to another.

(3) These rules shall not preclude the uniform application of coordination of benefits arrangements between the health maintenance organization and other alternatives included in the health benefits plan at the time of transfer from one alternative to another.

History: 1979 AC.

R 325.6920 Option of membership in health maintenance organization; availability to certain eligible employers; affirmative written selection.

Rule 920. (1) The option of membership in a health maintenance organization shall be available to new employees who become eligible, eligible employees who have transferred or otherwise changed their place of employment resulting in eligibility for membership in a health maintenance organization, and eligible employees covered by an alternative which ceases to be included in the employer's health benefits plan. The option of membership in a health maintenance organization shall be available without a waiting period.

(2) A newly eligible employee, eligible employee transferred from one employer location to another, and an eligible employee covered by an alternative which ceases to be included in an employer's health benefits plan shall make an affirmative written selection among the different alternatives included in the health benefits plan.

History: 1979 AC.

R 325.6925 Access to employees during group enrollment periods.

Rule 925. (1) The employer shall provide each health maintenance organization which is included in its health benefits plan fair and reasonable access during group enrollment periods to eligible employees for purposes of presenting and explaining the health services plan of the health maintenance organization. This access shall include, at a minimum, the opportunity for distribution of educational literature, brochures, announcements, and other relevant printed information approved by the insurance bureau.

(2) Access to eligible employees provided to health maintenance organizations shall not be more restrictive or less favorable than that provided other offerers of alternatives included in the health benefits plan, whether or not the representatives of the other alternatives elect to avail themselves of such access.

(3) The employer or designee and the bargaining representative shall be afforded the opportunity to review and approve all material before distribution to employees. The review shall be conducted in a timely manner to preclude a delay in the group enrollment period.

History: 1979 AC; 1988 AACS.

R 325.6930 Option of membership in health maintenance organization; time of offer.

Rule 930. (1) The employer or designee shall offer eligible employees the option of membership in a health maintenance organization at the earliest date permitted under the terms of existing collective bargaining agreements or employer-employee contracts.

(2) If an existing collective bargaining agreement is in force at the time the request for inclusion in the health benefits plan is made, the request shall be raised in the collective bargaining process when a new contract is negotiated, or, if the bargaining agreement is automatically renewable, then on its anniversary date or at such other times as may be provided by the agreement for discussion of changes in its provisions.

(3) In the absence of a collective bargaining agreement, if there is an existing employer-employee contract or a health benefits plan, the option shall be included in any health benefits plan offered to eligible employees when the existing contract is renewed or when a new health benefits contract or other arrangement is negotiated. If an employer-employee contract or health benefits contract has no fixed term or has a term in excess of l year, the contract shall be treated as renewable on the earliest annual anniversary date of the contract.

(4) If the employer is self-insured, the budget year shall be treated as the term of the existing contract.

(5) For an employer with multiple contracts or other arrangements included as part of the health benefits plan, which may have different expiration or renewal dates, the offer shall be included for each contract or arrangement at the time each contract or arrangement is offered to employees.

History: 1979 AC; 1988 AACS.

R 325.6935 Selection of nominal payment levels and supplemental services.

Rule 935. (1) For eligible employees represented by a bargaining representative, the selection of supplemental services and nominal payment levels shall be subject to the collective bargaining process.

(2) For eligible employees not represented by a bargaining representative, the selection of nominal payment levels and supplemental services to be offered to eligible employees shall be made through the decision-making process that exists with respect to the existing health benefits plan.

(3) For purposes of these rules, nominal payments and deductibles, as used in a health maintenance contract, shall not exceed 50% of the reasonable charge of the service.

History: 1979 AC; 1988 AACS.

R 325.6940 Terms of health maintenance organization alternative; employer's contribution or designee's costs.

Rule 940. (1) The health maintenance organization alternative shall be included in the health benefits plan on terms no less favorable than those on which the other alternatives in the health benefits plan are included.

(2) The administrative expense incurred in connection with offering any alternative in the health benefits plan shall not be considered in determining the amount of the employer's contribution to the health maintenance organization.

(3) The amount of the employer's contribution or designee's costs may exclude the portions of the contribution allocable to other fringe benefits for which eligible employees, or eligible employees and their eligible dependents, will continue to be covered, notwithstanding selection of membership in the health maintenance organization, and which benefits are not offered on a prepaid basis by the health maintenance organization to the employer's eligible employees.

History: 1979 AC.

R 325.6945 Employer's contribution fixed by agreement or law.

Rule 945. (1) Where the specific amount of the employer's contribution for health benefits is fixed by a collective bargaining agreement, by an employer-employee contract, or by law, the amount so determined shall constitute the employer's obligation for contribution toward the health maintenance organization prepaid rate on behalf of eligible employees or eligible employees and their eligible dependents.

(2) Where the employer's contribution for health benefits is determined by a collective bargaining agreement, but the amount fixed includes a contribution for benefits in addition to health benefits, the employer shall determine, or shall instruct its designee to determine, that portion of the employer's contribution applicable directly to health benefits.

History: 1979 AC.

R 325.6950 Employer's contribution not fixed by agreement.

Rule 950. In the absence of a collective bargaining agreement or employer-employee contract specifying the level of contribution to the health maintenance organization on behalf of eligible employees or eligible employees and their eligible dependents, unless otherwise agreed to by the health maintenance organization and the employer or its designee, the level of contribution shall be based upon the total costs of such health benefits offered to the employees for the most recent period for which experience is available, reduced by the amounts identified in accordance with these rules.

History: 1979 AC; 1988 AACS.

R 325.6955 Determination of employer's contribution or designee's costs; retention and review of data.

Rule 955. (1) An employer's contribution or designee's costs for the alternatives within the health benefits plan, other than the health maintenance organization option, shall be determined in the following manner, unless otherwise agreed to by the health maintenance organization and the employer or its designee:

(a) If the employer's contribution or designee's costs for health benefits with respect to the non-health maintenance organization alternative is determined solely on the basis of a fixed prospective amount, not subject to retrospective adjustment, contributed by the employer or paid by the designee, then the organizational alternative for the provision of health benefits to eligible employees, or to eligible employees and their eligible dependents, under the alternatives shall be used as the basis for determining the employer's level of contribution toward the health maintenance organization's prepaid rate.

(b) If the employer's contribution or designee's costs for health benefits with respect to the non-health maintenance organization alternative is determined by a contract with a carrier on any form of retrospective experience rating basis, any billing contract arrangement, any plan of self insurance, and direct service plan provided by the employer or its designee, or any other form of health benefit plan wherein the actual cost to the employer or its designee is determined retrospectively, an estimated cost shall be used to determine the level of contribution toward the health maintenance organization's prepaid rate. The estimated cost shall be determined by the employer or its designee taking into consideration factors relating to the following:

(i) The cost experience of the non-health maintenance organization alternative.

(ii) Allowance for inflation.

(iii) Cost differences experienced in the provision of health benefits for separate regional or local areas of employment.

(iv) Anticipation changes in the composition and experience of the covered population actually served by the non-health maintenance organization alternative attributable to the shift of enrollment to the health maintenance organization.

(v) Changes in health benefits provided by non-health maintenance organization alternatives.

(vi) Other material change in the experience rating basis under any health benefits contract for the contract year.

(2) An employer or designee shall retain, for not less than 3 years, the data used to compute its level of monetary contribution to the alternatives included in the health benefits plan. The data may be reviewed by the insurance bureau to determine whether the levels of contribution determined by the employer comply with these rules.

History: 1979 AC; 1988 AACS.

R 325.6960 Summary report to employer.

Rule 960. The health maintenance organization included as an alternative in the employer's health benefit plan shall annually provide the employer, upon request, with a summary report including the same information provided to subscribers pursuant to section 21085 of the act.

History: 1979 AC; 1988 AACS.

R 325.6965 Rescinded.

History: 1979 AC; 1988 AACS.