NORTH CAROLINA GENERAL ASSEMBLY
1977 SESSION

CHAPTER 580
HOUSE BILL 276

AN ACT TO PROVIDE FOR THE REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Section 1. The General Statutes of North Carolina are revised and amended to include a new Chapter to be denominated Chapter 57A and to read as follows:

"**CHAPTER 57A.**

"**§ 57A-1. Short title. —** This act may be cited as the Health Maintenance Organization Act of 1977.

"**§ 57A-2. Definitions.**

(a) 'Commissioner' means the Commissioner of Insurance.

(b) 'Basic health care services' means health care services which an enrolled population might reasonably require in order to be maintained in good health, including as a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services.

(c) 'Enrollee' means an individual who has been enrolled in a health care plan.

(d) 'Evidence of coverage' means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.

(e) 'Health care plan' means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of arranging for or the provision of health care services, as distinguished from mere indemnification against the cost of such services on a prepaid basis through insurance or otherwise.

(f) 'Health care services' means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care of hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(g) 'Health maintenance organization' means any person who undertakes to provide or arrange for one or more health care plans.

(h) 'Person' means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.

(i) 'Provider' means any physician, hospital, or other person that is licensed or otherwise authorized in this State to furnish health care services.

(j) 'Secretary' means the Secretary of Human Resources.

"**§ 57A-3. Establishment of health maintenance organizations. —** (a) Notwithstanding any law of this State to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this act. No person shall establish or operate a health maintenance organization in this State, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization

without obtaining a certificate of authority under this act. A foreign corporation may qualify under this act, subject to its registration to do business in this State as a foreign corporation under Article 17 of Chapter 58.

(b) (1) Notwithstanding anything contained in this act to the contrary, any person providing health services on a prepaid basis on July 1, 1977, shall, for purposes of this act, be deemed to be providing 'basic health care services' as defined in paragraph (b) of G.S. 57A-2 notwithstanding the fact that such person does not provide for inpatient hospital and physician care or care of a less comprehensive nature than as otherwise herein described. It is specifically the intention of this section to permit such persons to continue in operation in the manner in which they have heretofore operated without being required to provide the full range of 'basic health care services' as described in subsection (b) of G.S. 57A-2.

(2) Notwithstanding anything contained in this act to the contrary, any person providing health services on a prepaid basis on July 1, 1977, who has been providing services on a fee-for-services basis to persons who are not enrollees of the organization may continue to do so provided that the volume of services provided in this manner shall not be such as to affect the ability of the health maintenance organization to provide on an adequate and timely basis those services to its enrolled members which it has contracted to furnish under the enrollment contract.

(3) Notwithstanding anything contained in the act to the contrary, any person receiving federal funds under Section 254c of Title 42 of the United States Code as a 'community health center', as therein defined, shall, for purposes of this act, be deemed to be providing 'basic health care services' as defined in paragraph (b) of Section 57A-2 notwithstanding the fact that such person does not provide for inpatient hospital and physician care or care of a less comprehensive nature than as otherwise herein described.

(4) This act shall not apply to any employee benefit plan to the extent that the Federal Employee Retirement Income Security Act of 1974 preempts State regulation thereof.

(5) Except as provided in paragraphs (1), (2), (3) and (4) of this subsection, the persons to whom these paragraphs are applicable shall be required to comply with all provisions contained in this act.

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

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

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

(3) a list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(4) a copy of any contract made or to be made between any providers or persons listed in paragraph (3) and the applicant;

(5) a statement generally describing the health maintenance organization, its health care plan or plans, facilities, and personnel;

(6) a copy of the form of evidence of coverage to be issued to the enrollees;

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

(8) financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this act;

(9) a description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

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

(11) a statement reasonably describing the geographic area or areas to be served;

(12) a description of the complaint procedures to be utilized as required under G.S. 57A-22;

(13) a description of the procedures and programs to be implemented to meet the quality of health care requirements in G.S. 57A-4(a)(2);

(14) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under G.S. 57A-6(b);

(15) such other information as the commissioner may require to make the determinations required in G.S. 57A-4.

(d) (1) A health maintenance organization shall, unless otherwise provided for in this act, file a notice describing any modification of the operation set out in the information required by subsection (c). Such notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove within 30 days of filing, such modification shall be deemed approved.

(2) The commissioner may promulgate rules and regulations exempting from the filing requirements of paragraph (1) those items he deems unnecessary.

"**§ 57A-4. Issuance of certificate of authority. —**

(a) (1) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall forthwith transmit copies of such application and accompanying documents to the Secretary of Human Resources.

(2) The secretary shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:

a. has demonstrated the willingness and potential ability to assure that such health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility and continuity of service;

b. has arrangements, established in accordance with regulations promulgated by the secretary for an ongoing quality of health care assurance program concerning health care processes and outcomes; and

c. has a procedure, established in accordance with regulations of the secretary to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required by the secretary.

(3) Within 30 days of receipt of the application for issuance of a certificate of authority, the secretary shall certify to the commissioner whether the proposed health maintenance organization meets the requirements of paragraph (2). If the secretary certifies that the health maintenance organization does not meet such requirements, he shall specify in what respects it is deficient.

(b) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to Section 57A-3 within 30 days of receipt of the certification from the secretary. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in Section 57A-23 if the commissioner is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations.

(2) The secretary certifies, in accordance with subsection (a), that the health maintenance organization's proposed plan of operation meets the requirements of subsection (a)(2).

(3) The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

(4) The health maintenance organization has on hand as a financial reserve funds equal to at least three months' projected claims and operating expense (except that a health maintenance organization which has received federal grants in an amount equal to the financial reserve required under this subsection for at least two years prior to a current fiscal year and which certifies to the commissioner that it has an application pending for such a grant in a current fiscal year shall be exempt from this requirement), and the health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making the determinations required under this subsection, the commissioner may consider:

a. the financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in connection therewith;

b. the adequacy of working capital;

c. any agreement with an insurer, a hospital or medical service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

d. any agreement with providers for the provision of health care services;

e. any surety bond or deposit of cash or securities submitted in accordance with G.S. 57A-14 as a guarantee that the obligations will be duly performed; and

f. any firm commitment of federal funds to the health maintenance organization in the form of a grant, even though such funds have not been paid to the health maintenance organization, provided that the health maintenance organization certifies to the commissioner that such funds have been committed, that such funds are to be paid to the health maintenance organization within a current fiscal year and that such funds may be used directly for operating purposes and for the benefit of enrollees of the health maintenance organization.

(5) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to G.S. 57A-6.

(6) Nothing in the proposed method of operation, as shown by the information submitted pursuant to Section 57A-3 or by independent investigation, is contrary to the public interest.

(7) Any deficiencies certified by the secretary have been corrected.

(c) A certificate of authority shall be denied only after compliance with the requirements of G.S. 57A-22.

"**§ 57A-5. Powers of health maintenance organizations. —** (a) The powers of a health maintenance organization include, but are not limited to the following:

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

(2) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;

(3) the furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;

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

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

(6) the offering, in addition to basic health care services, of:

a. additional health care services;

b. indemnity benefits, covering out-of-area or emergency services; and

c. indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or hospital or medical service corporations.

(b) (1) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in subsections (a)(1) or (2). The commissioner shall

disapprove such exercise of power if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within 30 days of the filing, it shall be deemed approved.

(2) The commissioner may promulgate rules and regulations exempting from the filing requirement of paragraph (1) those activities having a de minimis effect.

"**§ 57A-6. Governing body. —** (a) The governing body of any health maintenance organization may include providers, other individuals, or both.

(b) Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

"**§ 57A-7. Fiduciary responsibilities. —** Any director, officer or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees.

"**§ 57A-8. Evidence of coverage and charges for health care services. —**

(a) (1) Every enrollee residing in this State is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a hospital or medical service corporation, whether by option or otherwise, the insurer of the hospital or medical service corporation shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

(2) No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this State until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(3) An evidence of coverage shall contain:

a. No provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading or deceptive as defined in G.S. 57A-15(a); and

b. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate of:

1. The health care services and insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

2. Any limitations on the services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

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

4. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan is contributory or noncontributory with respect to group certificates.

5. A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

(4) A copy of the form of the evidence of coverage to be used in this State, and any amendment thereto, shall be subject to the filing and approval requirements of subsection (b) unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or hospital or medical service corporations in which event the filing and approval provisions of such laws shall apply. To the extent, however, that such provisions do not apply the requirements in subsection (c) shall be applicable.

(b) (1) No schedule of charges for enrollee coverage for health care services, or amendment thereto, may be used in conjunction with any health care plan until a copy of such schedule, or amendment thereto, has been filed with and approved by the commissioner.

(2) Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory. A certification, by a qualified actuary, or such other certification as the commissioner deems appropriate, as to the appropriateness of the charges, based upon reasonable assumptions, shall accompany the filing along with adequate supporting information.

(c) The commissioner shall, within a reasonable period, approve any form if the requirements of paragraph (1) are met and any schedule of charges if the requirements of paragraph (2) are met. It shall be unlawful to issue such form or to use such schedule of charges until approved. If the commissioner disapproves such filing, he shall notify the filer. In the notice, the commissioner shall specify the reasons for his disapproval. A hearing will be granted within 30 days after a request in writing by the person filing. If the commissioner does not approve or disapprove any form or schedule of charges within 30 days of the filing of such forms or charges, they shall be deemed approved.

(d) The commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

"**§ 57A-9. Annual report. —** (a) Every health maintenance organization shall annually, on or before the first day of March, file a report verified by at least two principal officers with the commissioner, with a copy to the secretary covering the preceding calendar year.

(b) Such report shall be on forms prescribed by the commissioner and shall include:

(1) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant;

(2) any material changes in the information submitted pursuant to G.S. 57A-3(c);

(3) the number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year;

(4) a summary of information compiled pursuant to G.S. 57A-4(a)(2)c. in such form as required by the secretary; and

(5) such other information relating to the performance of the health maintenance organization as is necessary to enable the commissioner to carry out his duties under this act.

"**§ 57A-10. Information to enrollees. —** Every health maintenance organization shall annually provide to its enrollees:

(a) A statement summarizing its financial condition.

(b) A description of any changes in the organizational structure and operation of the health care plan which affects the nature, scope and location of the services available to enrollees.

(c) A description of services and information as to where and how to secure them. This requirement shall be waived if the initial informational material furnished to enrollees at the time of, or prior to, enrollment contains this information.

(d) A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints. This requirement shall be waived if the initial informational material furnished to enrollees at the time of, or prior to, enrollment contains this information, unless there are changes in the Health Maintenance Organization's method of resolving enrollee complaints.

"**§ 57A-11. Open enrollment. —**

(a) (1) A health maintenance organization which

a. has for at least 5 years provided comprehensive health services on a prepaid basis, or

b. has an enrollment of at least 50,000 members, shall have at least once during each fiscal year next following a fiscal year in which it did not have a financial deficit an open enrollment period (determined under paragraph (2)) during which it shall accept individuals for membership in the order in which they apply for enrollment and, except as provided in paragraph (3), without regard to preexisting illness, medical condition, or degree of disability.

(2) An open enrollment period for a health maintenance organization shall be the lesser of

a. 30 days, or

b. the number of days in which the organization enrolls a number of individuals at least equal to three percent (3%) of its total net increase in enrollment (if any) in the fiscal year preceding the fiscal year in which such period is held. For the purpose of determining the total net increase in enrollment in a health maintenance organization, there shall be included any individual who is enrolled in the organization through a group which had a contract for health care services with the health maintenance organization at the time that such health maintenance organization was organized and commenced to provide services.

(3) Notwithstanding the requirements of paragraph (1) a health maintenance organization shall not be required to enroll individuals who are confined to an institution because of chronic illness, permanent injury, or other infirmity which would cause economic impairment to the health maintenance organization if such individual were enrolled.

(4) A health maintenance organization may not be required to make the effective date of benefits for individuals enrolled under this subsection less than 90 days after the date of enrollment.

(5) The commissioner may waive the requirements of this subsection for a health maintenance organization which demonstrates that compliance with the provisions of this subsection would jeopardize its economic viability in its service area.

"**§ 57A-12. Complaint system. —**

(a) (1) Every health maintenance organization shall establish and maintain a complaint system which has been approved by the commissioner, after consultation with the secretary, to provide reasonable procedures for the resolution of written complaints initiated by enrollees concerning health care services.

(2) Each health maintenance organization shall submit to the commissioner and the secretary an annual report in a form prescribed by the commissioner after consultation with the secretary, which shall include:

a. a description of the procedures of such complaint system;

b. the total number of complaints handled through such complaint system and a compilation of causes underlying the complaints filed; and

c. the number, amount and disposition of malpractice claims settled during the year by the health maintenance organization and any of the providers used by it.

(b) The health maintenance organization shall maintain records of written complaints filed with it concerning other than health care services and shall submit to the commissioner a summary report at such times and in such format as the commissioner may require. Such complaints involving other persons shall be referred to such persons with a copy to the commissioner.

(c) The commissioner or the secretary may examine such complaint system.

"**§ 57A-13. Investments. —** With the exception of investments made in accordance with G.S. 57A-5(a)(1) and (2) and G.S. 57A-5(b), the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner may permit.

"**§ 57A-14. Protection against insolvency. —** Each health maintenance organization shall furnish a surety bond in an amount satisfactory to the commissioner, or deposit with the commissioner cash or securities acceptable to him in at least the same amount as a guarantee that the obligations to the enrollees will be performed. The commissioner may waive this requirement whenever satisfied that the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments, or other organizations are sufficient to reasonably assure the performance of its obligations.

"**§ 57A-15. Prohibited practices. —** (a) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any

exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist.

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

(b) The provisions of Article 3A of Chapter 58 of the General Statutes shall be construed to apply to health maintenance organizations, health care plans and evidences of coverage except to the extent that the commissioner determines that the nature of health maintenance organizations, health care plans and evidences of coverage render such sections clearly inappropriate.

(c) An enrollee may not be cancelled or not renewed because of any deterioration in the health of the enrollee.

(d) No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance", "casulty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

"**§ 57A-16. Regulation of agents. —** The commissioner may, after notice and hearing, promulgate such reasonable rules and regulations as are necessary to provide for the licensing of agents. An agent means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment.

"**§ 57A-17. Powers of insurers and hospital and medical service corporations. —** (a) An insurance company licensed in this State, or a hospital or medical service corporation authorized to do business in this State, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this act. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, hospital or medical service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(b) Notwithstanding any provision of the insurance and hospital or medical service corporation laws contained in Chapters 57 and 58 of the General Statutes, an insurer or a hospital or medical service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health care plan.

"**§ 57A-18. Examinations. —** (a) The commissioner may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements pursuant to its health care plan as often as he deems it necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

(b) The secretary may make an examination concerning the quality of health care services of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health care plan as often as he deems it necessary for the protection of the interest of the people of this State but not less frequently than once every three years.

(c) Every health maintenance organization and provider shall submit its books and records relating to the health care plan to such examinations and in every way facilitate them. For the purpose of examinations, the commissioner and the secretary may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

(d) The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner or the secretary for whom the examination is being conducted.

(e) In lieu of such examination, the commissioner or secretary may accept the report of an examination made by the Commissioner of Insurance or Commissioner of Public Health of another state.

"**§ 57A-19. Suspension or revocation of certificate of authority. —** (a) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this act if he finds that any of the following conditions exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under G.S. 57A-3, unless amendments to such submissions have been filed with and approved by the commissioner.

(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Section 57A-8.

(3) The health care plan does not provide or arrange for basic health care services.

(4) The secretary has certified to the commissioner that:

a. the health maintenance organization does not meet the requirements of G.S. 57A-4(a)(2); or

b. the health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan.

(5) The health maintenance organization no longer maintains the financial reserve specified in G.S. 57A-4(b)(4) or is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(6) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under G.S. 57A-6.

(7) The health maintenance organization has failed to implement the complaint system required by G.S. 57A-12 in a manner to reasonably resolve valid complaints.

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

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(10) The health maintenance organization has otherwise failed to substantially comply with this act.

(b) A certificate of authority shall be suspended or revoked only after compliance with the requirements of G.S. 57A-22.

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

(d) When the certificate of authority of a health maintenance organization is revoked, such 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 such 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 health care coverage.

"**§ 57A-20. Rehabilitation, liquidation, or conservation of health maintenance organization. —** Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies, except that the provisions of Articles 17B and 17C of Chapter 58 of the General Statutes shall not apply to health maintenance organizations. The commissioner may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon one or more grounds set out in Article 17A of Chapter 58 of the General Statutes or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this State.

"**§ 57A-21 Regulations. —** The commissioner may, after notice and hearing, promulgate reasonable rules and regulations as are necessary or proper to carry out the provisions of this act. Such rules and regulations shall be subject to review in accordance with G.S. 57A-22.

"**§ 57A-22 Administrative procedures. —** (a) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and the secretary in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days thereafter for a hearing on the matter.

(b) The secretary, or his designated representative, shall be in attendance at the hearing and shall participate in the proceedings. The recommendation and finding of the secretary with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority, shall be conclusive and binding upon the commissioner. After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the commissioner shall take action as is deemed advisable on written findings which shall be mailed to the health maintenance organization with a copy thereof to the secretary. The action of the commissioner and the recommendation and findings of the secretary shall be subject to review by the Superior Court of Wake County. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

(c) The provisions of Chapter 150A of the General Statutes of this State shall apply to proceedings under this section to the extent that they are not in conflict with subsections (a) and (b).

"**§ 57A-23. Fees. —** Every health maintenance 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, twenty dollars ($20.00);

(b) for filing each annual report, ten dollars ($10.00).

"**§ 57A-24. Penalties and enforcement. —** (a) The commissioner may, in lieu of suspension or revocation of a certificate of authority under G.S. 57A-19, levy an administrative penalty in an amount not less than one hundred dollars ($100.00) nor more than five hundred dollars ($500.00), if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation.

(b) Any person who violates this act shall be guilty of a misdemeanor and on conviction may be punished by a fine not to exceed five hundred dollars ($500.00) or by imprisonment for a period not exceeding two years or both, at the discretion of the court.

(c) (1) If the commissioner of the secretary shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner or secretary may give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner or the secretary may deem appropriate under the circumstances.

(d) (1) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.

(2) Within 30 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred. Such hearings shall be conducted pursuant to Chapter 150A of the General Statutes, and judicial review shall be available as provided by the said Chapter 150A.

(e) In the case of any violation of the provisions of this act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d), the commissioner may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court of Wake County.

"**§ 57A-25. Statutory construction and relationship to other laws. —** (a) Except as otherwise provided in this act, provisions of the insurance laws and provisions of hospital or medical service corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act.

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

(c) Any health maintenance organization authorized under this act shall not be deemed to be practicing medicine and shall be exempt from the provisions of Chapter 90 of the General Statutes relating to the practice of medicine.

"**§ 57A-26. Filings and reports as public documents. —** All applications, filings and reports required under this act shall be treated as public documents.

"**§ 57A-27. Confidentiality of medical information. —** Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this act; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

"**§ 57A-28. Secretary's authority to contract. —** The secretary, in carrying out his obligations under Sections 57A-4(a)(2), 57A-18(b) and 57A-19(a), may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the secretary.

"**§ 57A-29. Severability. —** If any section, term, or provision of this act shall be adjudged invalid for any reason, such 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."

Sec. 2. This act shall become effective on January 1, 1978.

In the General Assembly read three times and ratified, this the 16th day of June, 1977.