CHAPTER 33

Health Maintenance Organizations

**SECTION 38‑33‑10.** Short title.

 This chapter may be cited as the Health Maintenance Organization Act of 1987.

HISTORY: Former 1976 Code Section 38‑33‑10 [1962 Code Section 37‑331; 1968 (55) 2407; 1978 Act No. 441, Section 1] recodified as Section 38‑67‑10 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑25‑10 [1962 Code Section 37‑1132; 1974 (58) 2378] recodified as Section 38‑33‑10 by 1987 Act No. 155, Section 1; 1987 Act No. 83, Section 1 [amendment to former 1976 Code Section 38‑25‑10 transferred to Section 38‑33‑10 by 1987 Act No. 155, Section 24]; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑20.** Definitions.

 As used in this chapter:

 (1) "Basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services. It does not include dental services, mental health services, or services for alcohol or drug abuse, although a health maintenance organization at its option may elect to provide these services in its coverage.

 (2) "Director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. Furthermore, the director may bestow upon his designee or deputy director any duty or function required of him by law in managing or supervising the insurance department.

 (3) "Copayment" or "deductible" means the amount specified in the evidence of coverage that the enrollee shall pay directly to the provider for covered health care services, which may be stated in either specific dollar amounts or as a percentage of the negotiated rate or lesser charge of the provider. For good cause shown, the Director of the South Carolina Department of Insurance may, in his discretion, approve forms with provisions which vary from the provisions required in this subsection if he finds the provisions are more favorable to the enrollee.

 (4) "Employing entity" means a person employing one or more providers and agreeing to perform or provide a duty or function of the provider pursuant to this chapter, where the provider is prevented by contract with the employing entity or the employing entity's governing documents from performing such statutory duty or function individually. With respect to a statutory duty or function for which the employing entity acts for providers, an employing entity shall possess all corresponding rights and duties of its providers and shall be allowed to collectively satisfy such duty or function under this chapter as to all its providers (for example, by furnishing one hold harmless agreement and one participation agreement to a health maintenance organization on behalf of all the employing entity's providers).

 (5) "Enrollee" means an individual who is enrolled in a health maintenance organization.

 (6) "Evidence of coverage" means a certificate, an agreement, or a contract issued to an enrollee setting out the coverage to which he is entitled.

 (7) "Health care services" means services included in furnishing an individual medical or dental care or hospitalization or incident to the furnishing of care or hospitalization, and other services to prevent, alleviate, cure, or heal human illness, injury, or physical disability.

 (8) "Health maintenance organization" means a person who undertakes to provide or arrange for basic health care services to enrollees for a fixed prepaid premium.

 (9) "Person" means a natural or an artificial person including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

 (10) "Provider" means a physician, dentist, hospital, or other person properly licensed, where required, to furnish health care services.

 (11) "Designee or Deputy Director" means the person or person appointed by director, serving at his will and pleasure as his designee, to supervise and carry out the functions and duties of the department as provided by law. Any duty or function of the director to manage and supervise the insurance department may be conferred by the director's authority upon his designee or deputy director.

HISTORY: Former 1976 Code Section 38‑33‑20 [1962 Code Section 37‑332; 1968 (55) 2407; 1978 Act No. 441 Section 2] recodified as Section 38‑67‑20 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑25‑20 [1962 Code Section 37‑1131; 1974 (58) 2378] recodified as Section 38‑33‑20 by 1987 Act No. 155, Section 1; 1987 Act No. 83, Section 1 [amendment to former 1976 Code Section 38‑25‑20 transferred to Section 38‑33‑20 by 1987 Act No. 155, Section 24]; 1988 Act No. 622, Section 2; 1992 Act No. 403, Section 1; 1993 Act No. 181, Section 633; 1995 Act No. 58, Section 1; 1999 Act No. 98, Section 3.

**SECTION 38‑33‑30.** Necessity of certificate of authority; foreign corporation.

 (A) No person may establish or operate a health maintenance organization in this State without first obtaining a certificate of authority from the director or his designee. A foreign corporation, upon compliance with the provisions of this chapter, may be issued a certificate of authority upon further conditions that:

 (1) the applicant is registered as a foreign corporation to do business in this State;

 (2) the applicant is subject to regulation of its financial condition by authorities in its state of domicile, including regular financial examination not less frequently than once every three years; and

 (3) the applicant complies with such conditions as the director or his designee may prescribe with respect to the maintenance of books, records, accounts, and facilities in this State.

 (B) Each application for a certificate of authority must be verified by an officer or authorized representative of the applicant, must be filed in a form prescribed by the director or his designee, and must set forth the following:

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

 (2) a copy of the bylaws 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 management and conduct of the affairs of the applicant, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal offices 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 item (3) and the applicant;

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

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

 (7) financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statements satisfies this requirement unless the director or his designee directs that additional or more recent financial information is required for the proper administration of this chapter;

 (8) a description of the proposed method of marketing, a financial plan which includes a projection of operating results anticipated until the organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

 (9) a power of attorney duly executed by the applicant appointing the director and his authorized deputies or designees, as the lawful attorney of the applicant in this State upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this State may be served;

 (10) a statement reasonably describing the geographic area to be served;

 (11) a description of the complaint procedures to be utilized as required under Section 38‑33‑110;

 (12) a description of the procedures and programs to be implemented to meet the quality of health care requirements in Section 38‑33‑40;

 (13) a description of the mechanism by which enrollees have an opportunity to participate in matters of policy and operation under Section 38‑33‑60(2);

 (14) any other information as the director or his designee may require to make the determination required in Section 38‑33‑40.

 (C)(1) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall, unless otherwise provided for in this chapter, file a notice describing any material modification of the operation set out in the information required by subsection (B). The notice must be filed with the director or his designee prior to the modification. If the director or his designee does not disapprove within thirty days of filing, the modification is considered approved.

 (2) The department may promulgate regulations exempting from the filing requirements of item (1) those items he considers unnecessary.

 (D) An applicant or a health maintenance organization holding a certificate of authority shall file all contracts of reinsurance or a summary of the plan of self‑insurance. Any agreement between the organization and an insurer is subject to the laws of this State regarding reinsurance. All reinsurance agreements or summaries of plans of self‑insurance and any modifications thereto must be filed and approved. Reinsurance agreements shall remain in full force and effect for at least thirty days following written notice by registered mail of cancellation by either party to the director or his designee.

HISTORY: Former 1976 Code Section 38‑33‑30 [1962 Code Section 37‑333; 1968 (55) 2407; 1978 Act No. 441 Section 3] recodified as Section 38‑67‑30 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑25‑30 [1962 Code Section 37‑1133; 1974 (58) 2378] recodified as Section 38‑33‑30 by 1987 Act No. 155, Section 1; 1987 Act No. 83, Section 1 [amendment to former 1976 Code Section 38‑25‑30 transferred to Section 38‑33‑30 by 1987 Act No. 155, Section 24]; 1993 Act No. 181, Section 633; 1997 Act No. 68, Section 7.

**SECTION 38‑33‑40.** Issuance of certificate of authority; criteria and considerations; arrangements for participation of providers in each geographic area served.

 (A) The director or his designee shall issue a certificate of authority to a person filing an application pursuant to Section 38‑33‑30 if, upon payment of the application fee prescribed in Section 38‑33‑220, the director or his designee is satisfied that:

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

 (2) The health maintenance organization's proposed plan of operation has arrangements for an on‑going quality assurance program.

 (3) The health maintenance organization effectively provides or arranges for the provision of basic health care services for a fixed prepaid premium, except to the extent of reasonable requirements for deductibles or co‑payments.

 (4) The health maintenance organization is financially responsible, is able to meet its obligations to enrollees and prospective enrollees, and otherwise meets the requirements of this chapter. In making this determination, considerations by the director or his designee may include, but are not limited to:

 (a) the financial soundness of the arrangements for health care services and the schedule of charges used in connection with them;

 (b) the adequacy of working capital;

 (c) an agreement with an insurer, a government, or other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage if the health maintenance organization is discontinued;

 (d) an agreement with providers for the provision of health care services;

 (e) a deposit of cash or securities submitted in accordance with Section 38‑33‑130.

 (5) The enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to Section 38‑33‑60.

 (6) Nothing in the proposed method of operation, pursuant to Section 38‑33‑30 or by independent investigation, is contrary to the public interest.

 (B) No health maintenance organization may be licensed unless it has employed or contracted with or made arrangements satisfactory to the director or his designee with both physicians and hospitals to participate as providers in each geographic area to be served, as identified by the health maintenance organization under Section 38‑33‑30.

HISTORY: Former 1976 Code Section 38‑33‑40 [1962 Code Section 37‑334; 1968 (55) 2407; 1978 Act No. 441 Section 4] recodified as Section 38‑67‑40 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑25‑40 [1962 Code Section 37‑1134; 1974 (58) 2378] recodified as Section 38‑33‑40 by 1987 Act No. 155, Section 1; 1987 Act No. 83, Section 1 (amendment to former 1976 Code Section 38‑25‑40 transferred to Section 38‑33‑40 by 1987 Act No. 155, Section 24]; 1992 Act No. 403, Section 2; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑50.** Powers of health maintenance organization; notice prior to exercise of powers.

 (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 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 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 for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

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

 (7) providing services included in federal health care programs such as "Medicare", "Medicaid", "Champus", and veterans administration and other health programs funded in whole or in part by federal funds, in accordance with the laws governing these programs.

 (8) the offering of an out‑of‑network coverage under a point of service option; the Director of the Department of Insurance shall, by regulations and/or policy bulletin, implement the provisions of this item.

 (B)(1) A health maintenance organization shall file notice, with adequate supporting information, with the director or his designee prior to the exercise of any power granted in subsection (A)(1), (2), (4), or (7). The director or his designee may disapprove such exercise of power if in his opinion it would adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the director or his designee does not disapprove within thirty days of the filing, it is considered approved.

 (2) The department may promulgate regulations exempting from the filing requirement of item (1) those activities having a de minimis effect.

 (C) Any contract issued by a Health Maintenance Organization in this State on or after January 1, 1988, may include provision for subrogation by the Health Maintenance Organization to the enrollee's right of recovery against a liable third party for not more than the amount of insurance benefits that the Health Maintenance Organization has paid previously in relation to the enrollee's injury by the liable third party. If the director or his designee, upon being petitioned by the enrollee, determines that the exercise of subrogation by a Health Maintenance Organization is inequitable and commits an injustice to the enrollee, subrogation is not allowed. Attorney's fees and costs must be paid by the Health Maintenance Organization from the amounts recovered. This determination by the director or his designee may be appealed to the Administrative Law Court as provided by law in accordance with Section 38‑3‑210.

HISTORY: Former 1976 Code Section 38‑33‑50 [1962 Code Section 37‑335; 1968 (55) 2407; 1978 Act No. 441 Section 5] recodified as Section 38‑67‑50 by 1987 Act No. 155, Section 1; Former 1976 Code Section 38‑25‑50 [1962 Code Section 37‑1135; 1974 (58) 2378] recodified as Section 38‑33‑50 by 1987 Act No. 155, Section 1; 1987 Act No. 83, Section 1 [amendment to former 1976 Code Section 38‑25‑50 transferred to Section 38‑33‑50 by 1987 Act No. 155, Section 24]; 1993 Act No. 181, Section 633; 1999 Act No. 98, Section 1; 2000 Act No. 380, Section 2A.

**SECTION 38‑33‑60.** Members of governing body; advisory panels, etc.

 (A) The governing body of any health maintenance organization may include providers, or other individuals, or both.

 (B) The 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.

HISTORY: Former 1976 Code Section 38‑25‑60 [1962 Code Section 37‑1136; 1974 (58) 2378] recodified as Section 38‑33‑60 by 1987 Act No. 155, Section 1; 1987 Act No. 83, Section 1 [amendment to former 1976 Code Section 38‑25‑60 transferred to Section 38‑33‑60 by 1987 Act No. 155, Section 24]; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑70.** Fiduciary relationship in handling of funds.

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

HISTORY: Former 1976 Code Section 38‑25‑70 [1984 Act No. 512, Part II, Section 32] recodified as Section 38‑33‑70 by 1987 Act No. 155, Section 1; 1987 Act No. 83, Section 1 (amendment to former 1976 Code Section 38‑25‑70 transferred to Section 38‑33‑70 by 1987 Act No. 155, Section 24]; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑80.** Enrollee entitled to evidence of coverage; contents of evidence of coverage; discontinuance or replacement of coverage; charges for services.

 (A)(1) Every enrollee is entitled to an evidence of coverage issued by the health maintenance organization. If any of the enrollee's benefits are provided through an insurance policy, the insurer shall issue a separate evidence of coverage for those benefits provided. However, for a point of service option offered jointly by a health maintenance organization and an insurer, only one evidence of coverage is required, as long as the benefits provided by each party are clearly identified therein.

 (2) Evidence of coverage, or an amendment to it, may not be issued or delivered to a person in this State until a copy of the form of the evidence of coverage, or amendment to it, has been filed with and approved by the director or his designee pursuant to Section 38‑71‑310(A) or 38‑71‑720(A).

 (3) No evidence of coverage may contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in Section 38‑33‑140; and

 (4) An evidence of coverage must contain a clear and concise statement, if a contract, a summary, or a certificate, of:

 (a) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

 (b) any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or co‑payment feature;

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

 (d) 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;

 (e) clear and understandable description of the health maintenance organization's method for resolving enrollee complaints; and

 (f) the contract period during which the enrollee is entitled to health care services and benefits, the applicable charges for coverage during that contract period, and the time and manner in which charges and benefits under the contract or certificate can be changed. Any subsequent change may be evidenced in a separate document issued to the enrollee.

 (5) The director or his designee may require additional provisions in the evidence of coverage as may be necessary to the fair, just, and equitable treatment of enrollees. The additional provisions may include, but are not limited to, any of the provisions required of health insurance policies in Chapter 71 of Title 38 and regulations promulgated thereunder, if in the opinion of the director or his designee, the provisions are appropriate for the coverages provided under the health maintenance organization's evidence of coverage.

 (6) The provisions of Section 38‑71‑760 governing discontinuance and replacement of coverage are applicable to group health maintenance organization contracts, except to the extent that the director or his designee determines the provisions to be inappropriate to the coverage provided.

 (7) A health maintenance organization that issues a health maintenance organization contract which requires the enrollee to pay a specified percentage of the cost of covered health care services shall calculate those copayments and deductibles on the negotiated rate or lesser charge of the provider. Nothing in this section precludes a health maintenance organization from issuing a contract which contains fixed dollar copayments and deductibles.

 (B) No schedule of charges applicable to individual health maintenance organization contracts may be used until a copy of the schedule has been filed with and approved by the director or his designee. The director or his designee may disapprove this schedule of charges if it is determined that the benefits provided in the contracts are unreasonable in relation to the charges.

 (C) The director or his designee shall approve within thirty days any form if the requirements of subsection (A) are met. The director or his designee, in his discretion, may extend for up to an additional sixty days the period within which he shall approve or disapprove the form. The director or his designee shall approve, within a reasonable period, any schedule of charges if the requirements of subsection (B) are met. It is unlawful to issue a form or to use a schedule of charges until approved. If the director or his designee disapproves the filing, he shall notify the filer. The notice must contain the reasons for disapproval, and the filer, upon request in writing, is entitled to a public hearing on it. If action is not taken to approve or disapprove any form within thirty days of the filing of the form, if the period is not extended, or at the expiration of the extended period, if any, the filing is deemed approved. If action is not taken to approve or disapprove any schedule of charges within ninety days of the filing of the charges, the filing is deemed approved. An organization may not use a form or schedule of charges deemed approved pursuant to the default provision of this section until the organization has filed with the director or his designee a written notice of its intent to use the form or schedule of charges. The notice must be filed in the office of the director at least ten days before the organization uses the form or schedule of charges.

 (D) At any time the director or his designee, after a public hearing of which at least thirty days' notice has been given, may withdraw approval of a schedule of charges previously approved under subsection (B) or an evidence of coverage approved under subsection (A) if he determined that the schedule of charges or evidence of coverage no longer meets the standards for approval specified in this section.

HISTORY: Former 1976 Code Section 38‑25‑80 [1986 Act No. 440; repealed by 1987 Act No. 155, Section 25 (f)] recodified as Section 38‑33‑80 by 1987 Act No. 155, Section 1, and substance transferred to Section 38‑33‑290 by 1987 Act No. 83, Section 1; New Section 38‑33‑80 enacted by 1987 Act No. 83, Section 1; 1993 Act No. 181, Section 633; 1995 Act No. 58, Section 4; 1995 Act No. 58, Section 2; 1999 Act No. 98, Section 2; 2001 Act No. 82, Section 15, eff July 20, 2001.

**SECTION 38‑33‑90.** Statements and reports.

 (A) Every health maintenance organization annually shall file with the department by March first, in the form and detail the director or his designee prescribes, a statement showing the business standing and financial condition of the health maintenance organization on December thirty‑first of the preceding year, except that upon timely written request by the president or chief executive officer setting forth reasons why the statement cannot be filed within the time provided, the director or his designee may grant in writing an extension of filing time for not more than thirty days. This statement must conform substantially to the statement form adopted by the National Association of Insurance Commissioners. Unless the director or his designee provides otherwise, the annual statement is to be prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners.

 (B) The director or his designee may require every health maintenance organization to file quarterly reports and additional information considered necessary to enable the director or his designee to carry out his duties under this chapter. The reports and information must be furnished in the time and manner prescribed by the director or his designee.

 (C) Every health maintenance organization which is authorized to write business in this State shall file annually with the National Association of Insurance Commissioners by March first a copy of its annual statement convention blank along with any additional filings prescribed by the director or his designee for the preceding year. The information filed with the National Association of Insurance Commissioners must be in the same format and scope as that required by the director or his designee and must include the signed jurat page and the actuarial certification. Any amendments and addenda to the annual statement filing subsequently filed with the director or his designee also must be filed with the National Association of Insurance Commissioners. Foreign health maintenance organizations domiciled in a state which has a law substantially similar to this subsection are considered in compliance with this section.

 (D) In the absence of actual malice, members of the National Association of Insurance Commissioners, their authorized committees, subcommittees, and task forces, their delegates, National Association of Insurance Commissioners' employees, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks are acting as agents of the director or his designee under the authority of this section and are not subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required by this section.

HISTORY: Enacted as 1976 Code Section 38‑25‑90 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑90 by 1987 Act No. 155, Section 24; 1992 Act No. 403, Section 3; 1993 Act No. 181, Section 633; 2000 Act No. 312, Section 7.

**SECTION 38‑33‑100.** Financial requirements before issuance of certificate of authority to health maintenance organization.

 (A) No health maintenance organization may be issued a certificate of authority unless it is possessed of net worth of at least one million two hundred thousand dollars, six hundred thousand dollars of which must be capital if it is a stock health maintenance organization. After the issuance, the health maintenance organization shall maintain a net worth of not less than seven hundred fifty thousand dollars, six hundred thousand dollars of which must be capital if it is a stock health maintenance organization. Net worth means total assets less total liabilities. Instruments acceptable to the director or his designee may be utilized in determining net worth. If the director or his designee determines that the number of enrollees in the health maintenance organization is excessive or may become excessive in relation to the organization's net worth, the director or his designee may require that future enrollment be limited until it is no longer necessary.

 (B) If the surplus of a stock health maintenance organization is less than twenty‑five percent of the surplus initially required, as set forth in subsection (A), the health maintenance organization is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27.

 (C) If the capital of a stock health maintenance organization is impaired, the health maintenance organization is delinquent, and the director or his designee shall begin delinquency proceedings.

 (D) If the surplus of a licensed mutual health maintenance organization is less than the sum of the capital and minimum surplus required to be maintained by a stock health maintenance organization licensed to write the same kind or kinds of business, the mutual health maintenance organization is considered delinquent, and the director or his designee may begin delinquency proceedings as provided by Chapter 27.

 (E) If the surplus of a licensed mutual health maintenance organization is less than the minimum capital required to be possessed by a stock health maintenance organization licensed to write the same kind or kinds of business, the mutual health maintenance organization is delinquent, and the director or his designee shall begin delinquency proceedings.

HISTORY: Enacted as 1976 Code Section 38‑25‑100 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑100 by 1987 Act No. 155, Section 24; 1991 Act No. 13, Section 26; 1993 Act No. 181, Section 633; 2000 Act No. 312, Section 8.

**SECTION 38‑33‑110.** Complaint procedures; reports; malpractice claims; applicability of Freedom of Information Act.

 (A)(1) Every health maintenance organization shall establish and maintain a complaint system which is approved by the director or his designee to provide reasonable procedures for the resolution of written complaints initiated by enrollees.

 (2) Each health maintenance organization, with the annual report required in Section 38‑33‑90, shall submit to the department an annual report in a form the director prescribes which must include:

 (a) a summary of written complaints handled through the health maintenance organization's approved complaint system. The summary must include the total number of complaints organized by the nature of the complaint and the average time taken to resolve the complaint;

 (b) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that it settled during the year.

 (B) The director or his designee at any time may examine the complaint system. Information concerning complaints and malpractice claims filed pursuant to this section must be held in confidence and are not subject to disclosure under the Freedom of Information Act.

HISTORY: Enacted as 1976 Code Section 38‑25‑110 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑110 by 1987 Act No. 155, Section 24; 1992 Act No. 403, Section 4; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑120.** Investment of funds.

 With the exception of investments made in accordance with Section 38‑33‑50 (A)(1) and (2) and (B), the funds of a health maintenance organization must be invested only in securities or other investments permitted by the laws of this State for the investment of assets which qualify to cover policyholder obligations of life insurance companies or such other securities or investments as the director or his designee may permit.

HISTORY: Enacted as 1976 Code Section 38‑25‑120 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑120 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑130.** Security deposit; individual stop‑loss coverage; provisions for unpaid claim liability; individual conversion policy.

 (A) Each health maintenance organization shall deposit and maintain with the department cash or securities which qualify as legal investments under the laws of this State for public sinking funds in the amount of three hundred thousand dollars. The director or his designee may require a health maintenance organization to make deposits in excess of the amount specified in this section if in his opinion the additional deposits are necessary for the protection of enrollees and the public. All income from deposits must belong to the depositing organization and must be paid to it as it becomes available. A health maintenance organization that has made a security deposit may withdraw that deposit or part of it after making a substitute deposit of cash, securities, or a combination of these of equal amount and value. Securities must be approved by the director or his designee before being substituted. The return of cash or securities deposited with the department by a health maintenance organization pursuant to this section is governed by Section 38‑9‑150.

 (B) Each health maintenance organization shall require every provider who participates in the health maintenance organization and furnishes health care services to the health maintenance organization's enrollees to execute an agreement not to bill the enrollees or otherwise hold the enrollees financially responsible for services rendered. Provided, an employing entity may execute one agreement on behalf of the employing entity and all of its providers. An employing entity may also execute one participation agreement and one of other similar required forms on behalf of the employing entity and all of its providers. The provider's agreement must be given on forms prescribed or approved by the director or his designee, shall extend to all services furnished to the enrollee during the time he was enrolled in the health maintenance organization, and shall apply even where the provider or employing entity had not been paid by the health maintenance organization.

 (C) A health maintenance organization shall procure and maintain a policy of individual excess stop‑loss coverage provided by an insurance company licensed by the State. The policy also must include provisions to cover all incurred, unpaid claim liability in the event of the termination of the health maintenance organization due to insolvency or otherwise. In addition, the director or his designee may require that the policy provide that the insurer will issue an individual policy to an enrollee upon termination of the health maintenance organization or the ineligibility of the enrollee for further coverage in the health maintenance organization.

HISTORY: Enacted as 1976 Code Section 38‑25‑130 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑130 by 1987 Act No. 155, Section 24; 1988 Act No. 622, Section 3; 1992 Act No. 280, Section 3; 1993 Act No. 181, Section 633; 1999 Act No. 98, Section 4; 2012 Act No. 137, Section 6, eff April 2, 2012.

**SECTION 38‑33‑140.** Advertisements; application of provisions relating to trade practices; use of term "insurer" or "health maintenance organization".

 (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 chapter:

 (1) A statement or item of information is considered to be untrue if it does not conform to fact in any respect which is significant to a reasonable person enrolled in, or considering enrollment with, a health maintenance organization.

 (2) A statement or item of information is considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the 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 maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

 (3) An evidence of coverage is considered to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, causes a reasonable person, not possessing special knowledge regarding health maintenance organizations 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 maintenance organization issuing the evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

 (B) Chapter 57, Title 38 is construed to apply to health maintenance organizations and evidences of coverage except to the extent that the director or his designee determines that the nature of health maintenance organizations and evidences of coverage render such sections clearly inappropriate.

 (C) A health maintenance organization may not cancel or refuse to renew an enrollee, except for reasons stated in the organization's regulations applicable to all enrollees, or for the failure to pay the charge for such coverage, or for such other reasons as may be promulgated by the department.

 (D) No health maintenance organization may refer to itself as an insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in the state.

 (E) Any person not in possession of a valid certificate of authority issued pursuant to this chapter may not use the phrase "health maintenance organization" or "HMO" in the course of operation.

HISTORY: Enacted as 1976 Code Section 38‑25‑140 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑140 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑150.** Agent for organization; exemption from licensing requirements.

 (A) An agent means a person who is appointed or employed by a health maintenance organization and who engages in solicitation of membership in the organization. This definition does not include a person enrolling members on behalf of an employer, union, or other organization to whom a master subscriber contract has been issued.

 (B) The department may by regulation exempt certain classes of persons from the requirement of obtaining a license:

 (1) if the functions they perform do not require special competence, trustworthiness, or the regulatory surveillance made possible by licensing; or

 (2) if other existing safeguards make regulation unnecessary.

HISTORY: Enacted as 1976 Code Section 38‑25‑150 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑150 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑160.** Operation of health maintenance organization by insurance company; contracts for cost of care.

 (A) An insurance company licensed in this State may through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this chapter. Any two or more such insurance companies or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization.

 (B) An insurer 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. Among other things, under such contracts, the insurer may make benefit payments to health maintenance organizations for health care services rendered by providers.

HISTORY: Enacted as 1976 Code Section 38‑25‑160 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑160 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑170.** Examination of affairs of organization; quality of health care services; books and records; expense of examination; reports.

 (A) The director or his designee may make an examination of the affairs of a health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every five years. The director or his designee may accept the report of an examination made by the state where the health maintenance organization is domiciled.

 (B) The director or his designee may make an examination concerning the quality of health care service of a health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every five years.

 (C) Every health maintenance organization and provider shall submit its relevant books and records for the examinations and facilitate them. For the purpose of examinations, the director or his designee and the department may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.

 (D) The expenses of examinations under this section are assessed against the organization being examined and remitted to the director or his designee for whom the examination is being conducted.

HISTORY: Enacted as 1976 Code Section 38‑25‑170 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑170 by 1987 Act No. 155, Section 24; 1992 Act No. 403, Section 5; 1993 Act No. 181, Section 633; 2018 Act No. 219 (H.4657), Section 3, eff May 18, 2018.

Effect of Amendment

2018 Act No. 219, Section 3, in (A), in the first sentence, substituted "five years" for "three years"; and in (B), substituted "five years" for "three years".

**SECTION 38‑33‑180.** Suspension or revocation of certificate of authority.

 (A) The director or his designee may suspend or revoke a certificate of authority issued to a health maintenance organization if he finds that one or more of the following conditions exist:

 (1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in other information submitted under Section 38‑33‑30, unless amendments to the submissions have been filed with and approved by the director or his designee.

 (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 38‑33‑80.

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

 (4) The health maintenance organization does not meet the requirements of Section 38‑33‑40 or is unable to fulfill its obligations to furnish health care services.

 (5) The health maintenance organization is financially unsound or reasonably may 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 Section 38‑33‑60.

 (7) The health maintenance organization has failed to implement the complaint system required by Section 38‑33‑110 in a reasonable manner to resolve valid complaints.

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

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

 (10) The health maintenance organization otherwise has failed to comply with this chapter or regulations promulgated under it by the department.

 (B) A certificate of authority is suspended or revoked only after compliance with the requirements of Section 38‑33‑210.

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

 (D) When the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It may not engage in further advertising or solicitation. The director or his designee, by written order, may permit further operation of the organization he finds to be in the best interest of enrollees, to the end that enrollees are afforded the greatest practical opportunity to obtain continuing health care coverage.

HISTORY: Enacted as 1976 Code Section 38‑25‑180 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑180 by 1987 Act No. 155, Section 24; 1992 Act No. 403, Section 6; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑190.** Rehabilitation, liquidation, or conservation of a health maintenance organization; priorities.

 Any rehabilitation, liquidation, or conservation of a health maintenance organization is considered to be the rehabilitation, liquidation, or conservation of an insurance company and must be conducted under the supervision of the director or his designee pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The director or his designee may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in Sections 38‑27‑310 and 38‑27‑370, 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. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

HISTORY: Enacted as 1976 Code Section 38‑25‑190 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑190 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑200.** Implementation of regulations.

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

HISTORY: Enacted as 1976 Code Section 38‑25‑200 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑200 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑210.** Notification of grounds for denial, suspension or revocation of certificate of authority; hearings; judicial review.

 (A) When the director or his designee 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 in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least thirty days thereafter for a hearing on the matter. However, if the ground for suspension or revocation relates solely to financial condition, the director or his designee may immediately and without hearing suspend the certificate of authority of the health maintenance organization.

 (B) The provisions of Article 3, Chapter 23, Title 1, apply to administrative proceedings under this section. Whenever the director or his designee issues an order of suspension without an administrative hearing before the director or his designee based upon a health maintenance organization's financial condition, as authorized under subsection (A), the health maintenance organization has a right to judicial review before the Administrative Law Court in accordance with law.

HISTORY: Enacted as 1976 Code Section 38‑25‑210 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑210 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑220.** Fees.

 (A) Every health maintenance organization subject to this chapter shall pay to the department the following fees:

 (1) for filing an application for a certificate of authority, two thousand dollars;

 (2) for filing an amendment to the organization documents that requires approval, one hundred dollars;

 (3) for filing each annual report, one thousand dollars;

 (4) for transferring a certificate of authority from one entity to another which qualifies for such a certificate of authority, two thousand dollars.

 (B) Fees charged under this section must be deposited in the general fund of the state. Fees required in this section must be fully earned when paid and are not refundable, proratable, nor transferable.

HISTORY: Enacted as 1976 Code Section 38‑25‑220 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑220 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑230.** Levy of administrative penalty in lieu of revocation or suspension of certificate of authority; monetary penalty; notice and hearings; injunctions.

 (A) The director or his designee, in lieu of revocation or suspension of a certificate of authority under Section 38‑33‑180, may levy an administrative penalty of not more than fifteen thousand dollars for each violation of state or federal law the Department of Insurance is authorized to enforce or ground as prescribed therein. A series of acts by an organization which merely implement a basic violation and are not separate and distinct violations of an independent nature are considered to be part of the basic violation and only one penalty may be imposed. A monetary penalty may be imposed under this paragraph only after notice and an opportunity to be heard have been afforded in accordance with Section 38‑33‑210.

 (B) Whenever the director or his designee has reason to believe that any person has transacted the business of, or is about to transact the business of, a health maintenance organization without a certificate of authority, he may cause a complaint to be filed in the court of common pleas of Richland County to enjoin and restrain the unauthorized transaction of business. The court has power to make and enter an order or judgment awarding such preliminary or final injunctive relief as may be necessary and proper. In addition, the court may impose a civil penalty of not more than ten thousand dollars upon such person for each unauthorized act of business so transacted.

HISTORY: Enacted as 1976 Code Section 38‑25‑230 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑230 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633; 2018 Act No. 219 (H.4657), Section 4, eff May 18, 2018.

Effect of Amendment

2018 Act No. 219, Section 4, in (A), in the first sentence, deleted "may" following "his designee", and inserted "of state or federal law the Department of Insurance is authorized to enforce" following "each violation".

**SECTION 38‑33‑240.** Application of provisions of insurance law or law relating to solicitation or advertising by health professionals; practice of medicine, dentistry or other healing profession.

 (A) Except as otherwise specifically provided, the provisions of the insurance law do not apply to any health maintenance organization granted a certificate of authority under this chapter.

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

 (C) No health maintenance organization authorized under this chapter is considered to be practicing medicine, dentistry, or other healing professions.

HISTORY: Enacted as 1976 Code Section 38‑25‑240 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑240 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑250.** Records of organization as public documents; trade secrets, etc.

 All applications and filings required under Section 38‑33‑30 and any annual and quarterly financial reports required under Section 38‑33‑90 must be treated as public documents. Nothing herein may be construed to require disclosure of trade secrets, privileged or confidential commercial information, or replies to a specific request for information made by the director or his designee.

HISTORY: Enacted as 1976 Code Section 38‑25‑250 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑250 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑260.** Confidentiality of health records.

 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 is confidential and may not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter, 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 the data or information is pertinent. A health maintenance organization is entitled to claim any statutory privileges against such disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

HISTORY: Enacted as 1976 Code Section 38‑25‑260 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑260 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑270.** Contractual powers of Department to assist in investigative duties; assessments for consulting expenses.

 (A) The director or his designee, in carrying out the obligations under Sections 38‑33‑40, 38‑33‑170(B), and 38‑33‑180(A), may contract with qualified persons to make recommendations concerning the determinations required to be made by him. The recommendations may be accepted in full or in part by the director or his designee.

 (B) The director or his designee may assess the health maintenance organization directly for consulting expenses incurred pursuant to subsection (A) and require the organization to remit payment directly to the consultant. These expenses must be reasonable. The director or his designee is not required to but may consider the results of a quality assurance examination made at an appropriate time by a person with whom the health maintenance organization has a contract to provide health care services or by a person who has a legitimate interest in the quality of care provided by the organization.

HISTORY: Enacted as 1976 Code Section 38‑25‑270 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑270 by 1987 Act No. 155, Section 24; 1992 Act No. 403, Section 7; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑280.** Acquisition or exchange of securities of a health maintenance organization; merger or consolidation of HMO.

 (A) No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the department and has sent to the health maintenance organization, information required by Section 38‑21‑70 and the offer, request, invitation, agreement, or acquisition has been approved by the director or his designee. Approval by the director or his designee is governed by Section 38‑21‑90.

 (B) The provisions of Section 38‑21‑250 shall apply to health maintenance organizations.

HISTORY: Enacted as 1976 Code Section 38‑25‑280 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑280 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633; 2002 Act No. 228, Section 6, eff May 1, 2002.

**SECTION 38‑33‑290.** Participation by physician, podiatrist, optometrist, or oral surgeon as provided in HMO.

 No health maintenance organization may prohibit any licensed physician, podiatrist, optometrist, or oral surgeon from participating as a provider in the organization on the basis of his profession. Nothing in this section may be construed to interfere in any way with the medical decision of the primary health care provider to use or not use any health professional on a case‑by‑case basis.

HISTORY: 1976 Code Section 38‑25‑80 [1986 Act No. 440; repealed by 1987 Act No. 155, Section 25(f)] recodified as Section 38‑33‑80 by 1987 Act No. 155, Section 1; substance transferred to Section 38‑33‑290 by 1987 Act No. 83, Section 1; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑300.** Liability for participation in quality of care or utilization review.

 There may be no monetary liability on the part of, and no cause of action may arise against, any person who participates in quality of care or utilization reviews by a peer review committee established in accordance with regulations of the department under Section 38‑33‑40(A)(2) for any act performed during such reviews, provided such person acts in good faith and without malice, has made a reasonable effort to obtain the facts of the matter, and reasonably believes that the action taken is warranted by the facts.

HISTORY: Enacted as 1976 Code Section 38‑25‑300 by 1987 Act No. 83, Section 1; recodified as Section 38‑33‑300 by 1987 Act No. 155, Section 24; 1993 Act No. 181, Section 633.

**SECTION 38‑33‑310.** HMO may contract with out‑of‑state provider.

 Nothing in this chapter may be construed to prevent a health maintenance organization from contracting with an out‑of‑state provider.

HISTORY: 1995 Act No. 58, Section 7.

**SECTION 38‑33‑325.** Obstetrician‑gynecologist services; referrals; authorization for services; member notification of plan provisions.

 (A) A health benefit plan shall allow a female enrollee thirteen years of age or older a minimum of two visits annually pursuant to the health benefit plan, without prior referral, to the health care services of an obstetrician‑gynecologist in the health benefit plan.

 (B) For any continuing treatment resulting from obstetrical or gynecological, or both, complications diagnosed during the two visits for a calendar year, authorization must be made for medical necessity directly by the health maintenance organization. Written communication should be sent by the obstetrician‑gynecologist to the patient's primary care physician regarding the condition being treated within a reasonable time after each visit.

 (C) A health benefit plan must notify its members of the provisions of this subsection (A). The information must be provided in the Summary Plan Description materials and enrollment materials.

 (D) For purposes of this section:

 (1) "Health benefit plan" means a health maintenance organization, a preferred provider plan, an exclusive provider plan, or other managed care arrangement plan;

 (2) "Health care services" means the full scope of medically necessary services provided by the participating obstetrician‑gynecologist in the care of or related to the female reproductive system and breasts.

HISTORY: 1998 Act No. 329, Section 2.