Health Maintenance Organization (HMO) & Alternative Health Care Financing and Delivery System (AFDS) Instructions for Application for a Michigan Certificate of Authority (COA)

Companies applying for a HMO or AFDS Michigan COA are subject to an application review process that involves the coordination of two different offices within the Michigan Department of Insurance and Financial Services (DIFS). The two offices are the Office of Insurance Evaluation, and the Office of Insurance Rates and Forms. DIFS provides all applicants with General Instructions and Office-Specific Instructions.

Please be sure to adhere to the general and office-specific instructions. The applicant is expected to demonstrate that each licensing requirement is met. **Applications that do not meet these requirements will not be accepted.**

All applicants are expected to be familiar with Michigan's insurance laws and regulations. For information regarding how to obtain a copy of Michigan's laws and regulations please see Item #14 of the General Instructions.

Applicants should be aware that it typically takes at least six months for DIFS to complete its review of an application, approve provider contracts, and verify all licensure requirements are met including an adequate provider network. The length of review is primarily due to the time needed to contract with an adequate provider network on approved contract templates. The timeframe for completing our review is very dependent on the quality of the application filed and the responsiveness of the applicant.

If you have any questions regarding the application or the review process, general or office-specific, please have them addressed **prior** to submitting your application. All contact names and telephone numbers are provided in Item #13 of the General Instructions.

*A. GENERAL INSTRUCTIONS (*Exhibit A*)*

1. The application is subject to the Freedom of Information Act (FOIA). Only an individual's personal financials will be held confidential. Personal information such as social security numbers and home addresses will be redacted by DIFS if a FOIA request is received. If any documents in the application are marked **Confidential,** the application will not be processed. Any requests to hold documents confidential other than those identified above must be submitted to our FOIA coordinator at DIFS-FOIA@michigan.gov and resolved prior to DIFS review of the application. Any requests to the FOIA coordinator should include justification and statutory authority to hold information confidential. Most FOIA exemption requests are denied.

2. Submit the cover letter and two copies of the application to DIFS at the address shown in Item #2 of the general Instructions. Place each copy of the application in a 3-ring binder with identifying information on the front and spine.

   The application should have three (3) exhibits. Each exhibit should contain the pertinent information and be organized as follows:

Exhibit A:	General Instructions
Exhibit B:	Office of Insurance Evaluation Specific
Exhibit C:	Office of Insurance Rates and Forms Specific

3. Submit the cover letter and two copies of the application to:

   Michigan Department of Insurance and Financial Services
   Office of Insurance Evaluation
   Attn: Application Coordinator
   P.O. Box 30220
   Lansing, MI 48909-7720

   If submitting by overnight mail, please use this address:

   Michigan Department of Insurance and Financial Services
   Office of Insurance Evaluation
   Attn: Application Coordinator
   Stevens T. Mason Building, 7th Floor
   535 W. Allegan Street
   Lansing, MI 48933-1521

4. Please include a $500 check payable to the "State of Michigan."

5. Complete the application **Cover Sheet (FIS 0273)**. Please be sure to provide all narratives and documents as instructed. Required information not applicable to your organization should be designated with the abbreviation "N/A" (not applicable). In addition, please provide an explanation as to why it is not applicable.

6. Designate an individual as the authorized representative on the **Certificate of Appointment for Authorized Representative (FIS 0274)**. This person will be the contact with whom all regulatory staff will maintain communication and with whom responsibility for regulatory compliance is vested. Report any change in the designation of the authorized representative by submitting a new Certificate of Appointment for Authorized Representative form (FIS 0274) to the Department of Insurance and Financial Services, Office of Insurance Evaluation, Attn: Application Coordinator, P.O. Box 30220, Lansing, MI 48909-7720 or Stevens T. Mason Building, 7th Floor, 535 W. Allegan Street, Lansing, MI 48933-1521.

7. Notify the appropriate division of any significant changes that occur or are discovered during the application review period. Promptly submit amended forms if any changes occur. Please file amendments and subsequent submissions in the same manner as

described in Item #1. Any amended documents are to be clearly dated and marked "AMENDED."

8. Place brochures, pamphlets and other items of various construction and size in an 8 ½" x 11" envelope. The envelope will serve as an individual page. Please label the envelope correctly and provide a brief description of its contents.

   Do not include the following within the application packet:
   - paper clips
   - staples
   - highlighting with colored markers
   - bound documents (exception permitted for financial reports or audited financials)
   - two-sided copies
   - reduction of material to less than 70% of the original

9. On the first page of each contract/agreement please designate its status (draft, proposed, executed, etc.).

10. If necessary, please obtain a **copy of the model trust indenture language (FIS 0284).**

11. If necessary, please obtain a **copy of the instructions for making a deposit with the State of Michigan (FIS 0285).**

12. Maintain an exact copy of the application to facilitate questioning during the review process.

13. Direct any General or Office-Specific questions to the appropriate staff as follows:

    - **Office of Insurance Evaluation**

      Exhibit A - **General Instructions**
      Application Coordinator 517-284-8756

      Exhibit B
      Section 1 thru Section 6
      Application Coordinator 517-284-8756

      Section 7 thru Section 13
      Domestic Monitoring
      Kristin Hynes 517-284-8753

    - **Office of Insurance Rates and Forms**

      Exhibit C
      Section 1 thru Section 10
      Managed Care Plans
      John Gardner 517-284-8698

Section 11
Insurance Rates and Forms
Karen Dennis 517-284-8692

14. Obtain a copy of the Michigan Insurance Code **online** (http://legislature.mi.gov/doc.aspx?mcl-chap500) or by contacting NILS Publishing at 800-423-5910.

15. Please be advised that compliance with the Michigan Insurance Code will likely be verified through an onsite examination prior to the issuance of a Certificate of Authority (COA).

16. If necessary, please contact the National Association of Insurance Commissioners at 816-842-3600 to obtain a company code number upon issuance of a COA.

17. Upon successful completion of the application process and receipt of a COA subsequent rate and form filings are required to be submitted to DIFS through the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing ("SERFF").

B. OFFICE-SPECIFIC INSTRUCTIONS

Office-specific instructions are available at the following:

Exhibit B – Office of Insurance Evaluation
Exhibit C – Office of Insurance Rates and Forms

Office of Insurance Evaluation (Exhibit B)

Health Maintenance Organization (HMO) & Alternative Health Care Financing and Delivery System (AFDS) Instructions for Application for a Michigan Certificate of Authority (COA)

Section 1 - Articles of Incorporation

Provide a copy of the Articles of Incorporation, including all amendments thereto. Articles should be filed with the Department of Licensing and Regulatory Affairs, Securities & Commercial Licensing Bureau, 2501 Woodlake Circle, P.O. Box 30018, Okemos, MI 48909.

The applicant is to be incorporated under the Business Corporation Act, Act. No. 284 of the Public Acts of 1972, Sections 450.1101 to 450.2098 of the Michigan Compiled Laws; the Nonprofit Corporation Act, Act No. 162 of the Public Acts of 1982, Sections 450.2101 to 450.3192 of the Michigan Compiled Laws.

Section 2 - Bylaws

Provide a copy of the applicant's bylaws dated and signed by a company officer. Bylaws should reflect, at a minimum, the location of the registered office; location of the books and records; governing body composition; process for nominating, electing and filling of vacancies; annual meeting date; quarterly board meetings; and definition of quorum.

Section 3 - Board of Directors and Officers

Provide a list of individuals responsible for the conduct of the applicant's affairs, including members of the board of directors, board of trustees or other governing body. Also provide a list of officers if the entity is a corporation. The list should include each individual's name, title, personal address and term of office. Ensure that each list includes an effective date.

Section 4 - Enrollee Board Member Election Procedure

Provide a written policy and election procedure for the election of adult enrollees to the governing board. The election must occur within the first 12 months of operation. Pursuant to *Section 3511* of the Michigan Insurance Code, a governing body must have no less than 1 individual who represents the health maintenance organization's membership. A health maintenance organization that is under a contract with Michigan to provide medical services authorized under subchapter XIX or XXI of the social security act shall comply with either of the following requirements:

1. A minimum of 1/3 of its governing body must be representatives of its membership consisting of enrollees of the organization who are not compensated officers,

employees, or other individuals responsible for the conduct of, or financially interested in, the organization's affairs.

2. The health maintenance organization must establish a consumer advisory council that reports to the governing body. The consumer advisory council must include at least 1 enrollee, 1 family member or legal guardian of an enrollee, and 1 consumer advocate.

The procedure shall provide:

1. Notice to subscribers for the nomination of adult enrollees.

2. Composition of nominating committee, its purpose and selection criteria for nominees.

3. Notification to selected nominees.

4. Notification to subscribers of the election process.

5. Opportunity for subscribers to vote for adult enrollees through a balloting procedure. Include timelines for issuing and receiving completed ballots.

6. Tabulation of votes and how tie votes will be resolved.

7. Notification to elected adult enrollees.

8. Notification of election results to subscribers. Notification should include a current list of all governing body members with adult enrollee board members identified.

9. Term of office of adult enrollee board members. Enrollee board members shall hold office for three years after their election, except that the terms of office following the first enrollee election may be adjusted to allow the terms of adult enrollee board members to expire on a staggered basis.

10. How vacancies will be handled. A vacancy among adult enrollee board members shall be filled by appointment by a simple majority of the remaining enrollee board members from individuals meeting the qualifications identified in this procedure. A vacancy shall be filled only for the unexpired portion of the original term.

Section 5 - Conflict of Interest

Provide a conflict of interest policy and procedure that provides full disclosure and discovery of any present or potential conflict of interest for any of the following persons: promoters, incorporators, a partnership or association, directors, trustees, members of the governing body, officers of the HMO/AFDS, chief actuary, general counsel and/or controller. The policy and procedure should state that any conflict would be made known to the governing body within 30 working days of the date of discovery. The policy is to be dated and signed by a company officer.

Section 6 – Disclosure Statements & Fingerprints

Please provide a disclosure statement using the NAIC Biographical Affidavit for each individual responsible for the conduct of the applicant's affairs. Disclosure statements are required for the following individuals:

- Members of the board of directors, or board of trustees;
- Individual(s) who are the Ultimate Controlling party (UCP). If the UCP is a corporation, please provide biographical affidavits for each of the members of the board of directors for the UCP;
- Officers of the applicant; and
- The entity's medical director.

Disclosure statements should contain original signatures. You can access the form at the following website: http://www.naic.org/documents/industry_ucaa_form11.pdf.

A LiveScan process is used to obtain fingerprints for individuals cited in the above paragraph. Please call the Application Coordinator at 517-284-8756 for details.

Section 7 – Organization Charts

Please provide organization and function charts. Each chart should be clearly labeled and have an effective date.

- The **organization chart** presents the identities of, percentage ownership of, and interrelationships between the applicant, its subsidiaries, tis parent company, and any other affiliates of the applicant. The ultimate controlling person should be identified at the top of the chart. All ownership interests of 10% or more must be identified. Any legal entity (or person who is not an employee) responsible for administration or fiscal affairs of the applicant must also be identified. Affiliate means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.
- **The Company should supply an organization chart in accordance with the NAIC's Annual Statement Instructions for Schedule Y, Part 1.**
- The **administrative organization chart** presents the interrelationships of departments and positions within the firm. Identify officers and personnel assigned to the positions.
- The **function chart** describes the job functions of the positions identified in the administrative organization chart.

Section 8 – Plan of Operation

Provide a narrative describing the applicant's operations. The plan of operation should cover the highlights and essential features of the information provided in the other portions of the application. At a minimum, the plan of operation must address these key questions or areas:

1. Who is providing the initial funding to start this operation?

2. What are the options for raising additional capital, if necessary?

3. How does the entity intend to comply with **Sections 3559(1), 3559(3), and 3561** of the Michigan Insurance Code?

4. How will the statutory deposit requirement be satisfied? Will the deposit be placed with the Michigan Department of Treasury (please see **(FIS 0285)** or Model Trust Indenture (please see **(FIS 0284)?**

5. Will the applicant be a for-profit or non-for-profit entity?

6. Will the applicant be a staff, network, independent practice association (IPA), group or combination model HMO?

7. Include a detailed discussion of the corporate organizational structure. This discussion should clearly identify any parent and affiliated entities and any ownership or contractual relationships with these entities. The discussion should clearly identify what individuals or corporations own the entities in the corporate structure. Also, any affiliated relationships or transactions should be included. Any services provided by affiliates must be covered and substantiated with a written agreement that clearly defines the services to be provided**,** outlines compensation for services rendered, and states when and how balances would be settled.

   An affiliated service agreements should be submitted (see below – Section 4). The applicant should note if it has any direct involvement (proprietary, voting or other decision –making authority) in policymaking or operation of another organization of if any organization has similar control over the applicant's operations. The name, address and FEIN number should be provided for all affiliates.

8. Identify and describe the products to be marketed and sold. Please provide income statement projections for each product for five years. Please see **(FIS 0317)** located in the **DIFS Forms & Instructions Booklet** for income statement format. Please be sure to comply with statutory accounting principles.

9. Include a description of how the applicant will maintain compliance with the books and records requirement of **Section 3548 and Section 5256** of the Michigan Insurance Code.

10. Identify third party administrators (TPAs) that will be utilized by the applicant. It is the responsibility of the applicant to ensure all TPAs are properly licensed.

Section 9 – Leases, Mortgages, Management Contracts, & Insurance Coverages

Provide all affiliated agreements for leases, mortgages, loans, grants, management service agreements, reinsurance agreements, liability coverage, or other documents to which the applicant is a party.

Designate the status (draft, proposed, in negotiation, executed) of each contract or service agreement. All executed agreements must be current and signed with all penned changes to the agreement initialed by both parties.

Management Agreement

A management agreement should contain the following components:

1. Services to be provided must be specific and the criteria used to evaluate performance under the agreement must be stated.

2. All books and records must clearly belong to the applicant.

3. If the entity providing management services is located outside of Michigan, complete access to records *must* be available to the Department of Insurance & Financial Services.

4. Both parties must be able to terminate the agreement.

5. Fees for services rendered should be easily ascertained and reasonable. Balances must be settled timely. How and when balances are settled should be stated.

(Note: If a management company processes claims on behalf of the applicant, that management company must be licensed as a TPA pursuant to Sections 3543 and 901 of the Michigan Insurance Code.)

Reinsurance Agreements

Pursuant to **Section 3559(1)** of the Michigan Insurance Code, HMO's are required to obtain a reinsurance contract or establish a plan of self-insurance as may be necessary to ensure solvency or protect subscribers in the event of insolvency. If the HMO wishes to obtain a reinsurance contract, the agreement must be with a reinsurer authorized or eligible to transact insurance in Michigan. Furthermore, the policy must contain an endorsement for insolvency, which is essentially a continuation of benefits provision required by **Section 3561** of the Michigan Insurance Code. Please be sure to include evidence of coverage. Provide the reinsurance agreement or, if the coverage is not purchased until licensed, a binder from the reinsurer that is executed upon licensure. **(Note: reinsurance coverage for HMO/AFDS is not similar to reinsurance coverage for a traditional insurer, but more a stop-loss coverage**

that limits or caps an HMO/AFDS' losses above certain individual and aggregate limits.)

Insurance Coverages

Applicants are required to maintain insurance *coverage* pursuant to **Section 3559(3)** of the Michigan Insurance Code. The applicant shall maintain insurance coverage to protect from excessive loss, which includes, but is not limited to, fire, theft, general liability, errors and omissions, directors and officers, fidelity, and malpractice/managed care liability insurance. Clearly label the type of insurance coverage provided. Include certificates of coverage for all insurance.

Section 10 – Financial Statements

Please provide the following:

1. The applicant's independent audited financial statements for the most recent fiscal year and subsequent monthly financial statements up to the most recent month available. If the audited financial statements are not available, please provide unaudited financial statements. Please be advised that projections will be weighed more heavily for determining the entity's suitability for a COA if audited financial statements are not available. All financial statements must be prepared in accordance with statutory accounting principles.

2. The financial statements of each stockholder and the entity's Ultimate Controlling Person (UCP). If the immediate owner(s) or the UCP is a corporation, please submit its audited financial statements. If the audited financial statements are on a consolidated basis, please be sure to include the consolidating work sheet in the notes. If the immediate owner(s) or the UCP is an individual, please submit their personal financial statements.

NOTE: A preliminary review upon receipt of your application will be performed to determine compliance with working capital and net worth requirements of Sections 3555 and 3551 of the Michigan Insurance Code. The application will not be accepted if the minimum requirements are not met. (A plan to meet the requirements is NOT acceptable.)

Section 11 – Accounting Procedures

Provide a description of the accounting procedures and practices to be used including written policies and procedures for expenditure control and approval, and premium collection. Describe in detail how claims will be accounted for and how the applicant will monitor claims payable particularly incurred but not yet reported claims (IBNR). In your description of the accounting systems to be used, clearly indicate the individual(s) that are responsible for each function.

Section 12 – Financial Plan

The financial plan should provide adequate detail to allow a review of the applicant's financial viability and profitability on a long-term basis. The NAIC has developed an excel spreadsheet for health projections, which can be located at http://www.naic.org/industry_ucaa.htm under ProForma Financial Statements (Health companies). Please note that this template only provides three years' worth of information and DIFS requires five years. The company's fiscal year must be on a calendar year basis. At a minimum, the financial plan should include the following:

1. Five-year projected balance sheet, income statement and cash flow statement. The first year's projections should be broken down on a quarterly basis.

   These projected financial statements should be prepared on an accrual basis and in accordance with statutory accounting principles.

2. The applicant's most recent RBC Report, if applicable, and five-year projection of RBC Ratios. For assistance with obtaining the necessary materials for computing the RBC ratio, please contact the National Association of Insurance Commissioners at 816-783-8300 or at the website of the NAIC's products and services division.

3. Demonstration that the applicant meets all financial requirements at the time the application is submitted and will stay in compliance with all financial requirements.

4. Description of methods, assumptions and projections used in the development of a financial plan such as anticipated utilization, expansion, and inflationary factors, etc.

5. Description of all assets that account for the initial surplus of the applicant.

6. Appropriate supporting financial, statistical or actuarial documentation. At a minimum, this support should include the method and assumptions inherent in the development of IBNR.

7. Identification of the current and/or prospective owners of the applicant and the source of the funding.

8. Documentation of the source of any additional funding projected in the financial plan.

9. Provide documentation that illustrates compliance with the minimum surplus requirements set for in **Section 3551**of the Michigan Insurance Code. For an AFDS, minimum surplus requirements are outlined in **Bulletin 2001-05-INS.**

10. Demonstrate compliance with the positive working capital requirement of **Section 3555(b)** and that the appropriate deposit amount as required by **Section 3553** of

the Michigan Insurance Code is satisfied. The deposit must be made prior to issuance of the Certificate of Authority.

Section 13 – Management Information System

Provide a description of management information system(s) to be used, including manual and machine systems. Include a system overview or flow chart, copies of input documents and a narrative of system procedures. Describe in detail the systems to be used to account for the general ledger, claims and premiums. The applicant must be able to adequately demonstrate it is capable of handling membership, marketing, claim processing, accounting and planning functions.

Office of Insurance Rates and Forms (Exhibit C)

Health Maintenance Organization (HMO) & Alternative Health Care Financing and Delivery System (AFDS) Instructions for Application for a Michigan Certificate of Authority (COA)

Section 1 - Marketing Plan

Provide a marketing and enrollment plan that includes the following information:

1. A description of the data, information, methodology, and assumptions used in projecting enrollment levels by enrollment category, including, at a minimum, an annual enrollment projection for the first three years of operation.

2. A description of the proposed marketing, sales, and enrollment methods, including a description of whether the plan will be marketed and sold by staff, marketing representatives, agents, or both.

3. A copy of established guidelines used to ensure accountability of marketing and sales representatives.

4. A health maintenance organization shall not use in its name, contracts, or literature the words “insurance”, “casualty”, “surety”, “mutual”, or any other words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of an insurance or surety corporation doing business in this state. **[Section 3503(3)**]. Any enrollee incentives shall comply with **Section 3517**.

5. All subscriber enrollment applications.

6. A description of the enrollment process.

7. The projected timeframe for processing applications.

8. Timeline(s) the applicant will have for issuing new subscribers’ member material, including but not limited to the following: certificate of coverage, membership card, and provider directory.

9. Provide a copy of the Patient Protection and Affordable Care Act required Summary of Benefits and Coverage template and Uniform Glossary.

Section 2 - Service Area

Pursuant to **Section 3509** of the Michigan Insurance Code, the applicant shall provide a description of the requested service area(s). The applicant shall identify each full and/or partial county in the requested service area. If the applicant is requesting approval to

serve a partial county, the requested areas within the partial county must be identified by townships and cities. If the applicant is requesting non-contiguous service areas, each service area shall be described separately. The applicant shall provide state and county map(s) showing the boundaries of the requested service area(s).

The applicant shall identify if the requested service area is to be for use associated on or off the Exchange or both.

Section 3 - Contracted Provider Network

An applicant must demonstrate that it has an adequate contracted provider network on provider contract formats approved by DIFS demonstrating compliance with **Sections 3428, 3513(2)(b) and (d), 3529(2) and (7)**, and **3530** of the Michigan Insurance Code. Available on the DIFS website are Michigan Service Area Maps and Network Adequacy Guidance to assist applicants in meeting network adequacy requirements.

The applicant must demonstrate that it has contracted with a comprehensive range of providers offering primary care, specialty, facility, and ancillary services as applicable to the health care services provided by the applicant, that are readily accessible and available to enrollees throughout the applicant's service area(s). A COA will not be issued until an applicant has at least one service area with an adequate contracted and credentialed provider network. Provide the following information:

1. A description of the ability to provide, within the requested service area, treatment of emergency episodes of illness or injury to enrollees 24 hours a day and 7 days a week. **[Section 3513(2)(b) and (d)]**

2. A description of the ability to provide, outside the applicant's approved service area, treatment of emergency episodes of illness or injury to enrollees 24 hours a day and 7 days a week. **[Section 3513(2)(d)]**

3. A description of the provider-covered person ratios by specialty and primary care provider.

4. A description of the standards of geographic accessibility to primary care physicians/sites, specialists, and hospitals. DIFS will not approve any service area for which the nearest contracted acute-care hospital is more than 30 minutes away. Exceptions may be allowed in rural areas where no hospital exists within a 30 minutes travel time to requested area. **[Section 3530(1)]**

5. A description of the process and standards to establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of enrollees. **[Section 3530(3)]**

6. A description of the standards of accessibility regarding availability of routine and urgent appointments, expected patient waiting times for routine and urgent appointments. **[Section 3530(1)]**

7. A written attestation from the authorized representative that if there is an insufficient number or type of participating providers in its contracted provider network to provide a covered benefit, the applicant shall ensure that the enrollee will obtain the covered benefit in a timely manner, geographically accessible, and at no greater cost than if the benefit were obtained from participating providers. **[Section 500.3530(2)]**

8. A completed Michigan Network Data Template (**FIS 2273** available on the DIFS website) detailing all providers by each county within the requested service area. At the time of filing the application, the listed providers should have executed letters of intent to become a contracted provider. DIFS will not accept substitutions of the Michigan Network Data Template.

9. Prior to the issuance of a COA an applicant must have completed its credentialing verification process for each listed provider**. [Section 3528]**

10. County specific maps showing the locations of the contacted providers (optional) identified in Michigan Network Data Template (**FIS 2273**). Include designated symbols and corresponding index for the identified providers.

11. Evidence that the applicant has provided an initial 60-day application period during which providers may apply to the applicant to become an affiliated provider**. [Section 3531(7)]**

12. If the applicant is proposing to provide health care coverage to small groups and individuals, it provides evidence that its provider network complies with Patient Protection and Affordability Care Act (PPACA) requirements pursuant to §2707 and 45 CFR §156.230 and § 156.236. AFDS applicants must comply with PPACA if applicable to its line of business.

Section 4 - Provider Contracts, Agreements and Arrangements for Service

Please provide all current, or proposed standard provider contract formats and agreements. **[Section 3529(6)]** Typical contract formats include, but are not limited to, the following":

1. Physician (primary care)
2. Physician (specialist)
3. Hospital
4. Pharmacy
5. Physician hospital organization (PHO)
6. Independent practice association (IPA)
7. Ancillary services (e.g. used for home health care, hospice, durable medical equipment, ambulance, etc.)

Each model contract must include a format of each attachment, exhibit, or addenda that is referenced in the model contract.

All contracts must contain a listing of covered services to be provided in conjunction with the proposed contract and the corresponding reimbursement methodology(ies) to be used.

Contracts which propose sharing risk with a provider or provider organization (e.g. IPA, PHO, Pharmacy Benefit Manager) must disclose all proposed risk provisions, including risk-sharing information pertaining to withhold amounts, fund allocations, risk corridors (may be expressed in a range) and the allocation of deficits and surplus. The applicant must also describe any method(s) used in the settlement of any risk-sharing pools or other risk-sharing arrangements.

Model contracts to be used by the applicant to contract with a provider organization (PHO, IPA, etc…) must contain all underlying contracts between the provider organization and its affiliated providers (including the reimbursement arrangements). All such underlying contracts must also meet the minimum requirements of **Section 3529** of the Michigan Insurance Code.

Section 5 - Subscriber and Group Contracts and Riders

Provide all proposed subscriber contracts, (group, individual, conversion, point-of-service, Medicaid etc…) riders, and amendments that, at a minimum, meet the requirements of **Section 3402, Section 3523** and contain the requirements pursuant to **Section 2212a** and applicable sections of **Chapters 22, 34, 35**, and **36** of the Michigan Insurance Code and requirements of the Patient Protection and Affordability Care Act. A listing of required elements necessary to be in a subscriber certificate is identified in Attachment 1 of this document.

Provide the applicant's enrollment application. **[Section 3523(2)]**

Section 6 - Quality Assessment Program

Provide approved policy and procedures for the applicant's quality assessment program that contains, at a minimum, the following information pursuant to **Section 3508(1)** of the Michigan Insurance Code:

1. Assessment of the quality of health care provided to enrollees.

2. Systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements.

In addition to the above requirements, provide approved policies, procedures and documentation addressing the following:

1. How the applicant will monitor its quality assessment program to ensure the provision of quality health care services.

2. The governing body's accountability for the quality assessment program,

including how the governing body will assure quality assessment policies and procedures are adopted, implemented, and revised as necessary.

3. Describe how the quality assessment program results will be routinely reported to the governing board, plan administration, and network providers.

4. Provide a copy of the medical director's Michigan medical license, vitae, and job description.

5. Provide an organizational chart of the applicant's current and/or future quality committee structure. Identify filled and vacant positions.

Section 7 - Quality Improvement Program

Provide a description, or approved policy and procedures, for the applicant's quality improvement program that contains, at a minimum, the following information pursuant to **Section 3508(2)** of the Michigan Insurance Code:

1. Design, measure, assess, and improve the processes and outcomes of health care as identified in the program. The quality improvement program shall be under the direction of the medical director and include:

    a. A written statement of the program's objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, and performance improvement activities.

    b. An annual effectiveness review of the program.

    c. A written quality improvement plan that, at a minimum, describes how the applicant analyzes both the process and outcome of care, identifies the targeted diagnoses and treatment to be reviewed each year, uses a range of appropriate methods to analyze quality, compare program findings with past performance and internal goals and external standards, measures the performance of affiliated providers, and conducts peer review activities.

In addition to the above requirements, provide description, or the applicant's approved policies and procedures, addressing how the applicant will do the following:

1. Adopt and communicate clinical practice and preventive guidelines to its providers.

2. Use clinical practice and preventive guidelines to assess and improve health care service quality.

3. Conduct peer review process, responsibilities, and evaluation of corrective actions.

4. Ensure health study sampling methodology is valid and based on the applicant's entire population.

5. Provide members with preventive health care education.

6. Conduct utilization review. Also describe, identify or provide a copy of the measurable criteria used for making utilization management decisions.

7. Conduct prior authorization for elective inpatient admission and the length of time necessary to perform this function.

8. Conduct inpatient hospitalization concurrent review and use appropriate length of stay norms (as necessary).

9. Develop or adopt inpatient length of stay norms.

10. Assess potential over and under utilization of services.

11. Conduct the applicant's case management program, and how it will identify and manage enrollees with complex health care conditions.

Section 8 - Health Professional Credentialing

Provide a credentialing verification process, or the applicant's approved policy and procedures, for credentialing and re-credentialing all contracted health professionals. The policies and procedures must address and contain all requirements pursuant to **Section 3528** of the Michigan Insurance Code.

1. Describe, or provide the applicant's policies and procedures, addressing how the applicant will ensure that the contracted primary care physician offices are maintained in a safe and sanitary condition in a manner consistent with public health and welfare and constructed to be free from hazards to enrollees, staff and visitors.

2. Provide a copy of the site visit tool used to conduct physician office site visits.

Section 9 - Complaint and Grievance Procedure

Provide grievance procedures that address the requirements contained in **Section 2213** of the Michigan Insurance Code as well as the **Patient's Right to Independent Review Act (PRIRA), Act 251 of the Public Acts of 2000**, Sections 550.1901 to 550.1929 of the Michigan Compiled Laws. A description of the elements necessary to comply with **Section 2213** is identified in Attachment 2 of this document. **Section 2213** and the PRIRA statute can be downloaded from the Internet at http://legislature.mi.gov/doc.aspx?mcl-500-2213 and http://legislature.mi.gov/doc.aspx?mcl-Act-251-of-2000**.**

Section 10 - Medicare Advantage Submission

The Center for Medicare and Medicaid (CMS) preempts DIFS' regulatory enforcement for Medicare Advantage Plans. However, in order to make the application complete for filing purposes the applicant is required to address Sections 2, 4, 6, 7, and 9.

Section 11 - Rates

NOTE: This section has been recently revised to reflect rate requirements effective January 1, 2014 for plans to be offered both on and off the Health Insurance Exchange pursuant to the Federal Affordable Care Act.

For plans offered **OFF** the Exchange **only**, provide the following information:

1. A schedule of rates, including rates for base plans and all optional riders.

2. Supporting methodology used in the development of all rates. This methodology must include the projected utilization (per 1,000 members per year) by service type and the projected cost per service. Where applicable, the cost data must be consistent with the payment methodology reflected in the applicant's provider agreements. The rates produced by this rating methodology must also be consistent with the revenue projections found in the financial plan. **[Section 3521]**

3. An actuarial certification or other narration from the applicant that explains the method used in the development of the projected cost and utilization of benefits as well as the applicant's administrative expenses.

4. Allowable factors used in the adjustment of rates (i.e. geographic area, age, tobacco, and family).

For plans offered **ON** the Exchange:

Rating rules apply to non-grandfathered Individual and Small Group plans. Both must be rated on a modified community rating basis using a single risk pool.

Rates may be adjusted using ONLY: age, family, tobacco use, and geography.

For assistance in meeting all the Federal rating requirements, the links below will be helpful:

Fact Sheet:
https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ratereview.html

Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf

Technical fact sheet on market reforms:
https://www.cms.gov/cciio/index.html

Technical fact sheet on rate review provisions:
https://www.cms.gov/cciio/index.html

Additionally, using the guidelines above, please include:

1. A schedule of rates for all QHPs.

2. Supporting methodology used in the development of all QHP rates. This methodology must include the projected utilization (per 1,000 members per year) by service type and the projected cost per service. Where applicable, the cost data must be consistent with the payment methodology reflected in the applicant's provider agreements. The rates produced by this rating methodology must also be consistent with the revenue projections found in the financial plan. **[Section 3521]**

3. An actuarial certification or other narration from the applicant that explains the method used in the development of the projected cost and utilization of benefits as well as the applicant's administrative expenses.

4. A written description of the methodology used in determining actual QHP rates charged to small groups and individuals. This must include any allowable factors used in the adjustment of rates (i.e. age, family, tobacco use, and geography).

If the same plan is offered both ON and OFF the Exchange, the rate must be the same both ON and OFF the Exchange.

Application Forms

FIS 0273 HMO/AFDS Application for Certificate of Authority
FIS 0274 Appointment for Authorized Representatives
FIS 2273 Michigan Network Data Template
FIS 0284 Model Trust Indenture
FIS 0285 Statutory Deposit Instructions

Attachment 1

Health Maintenance Organization (HMO)
Alternative Health Care Financing and Delivery System (AFDS)

Subscriber Contract

The subscriber contract shall address the following requirements contained in **Section 2212a** of the Michigan Insurance Code:

1. Provide a written form, in plain English, to enrollees upon enrollment that describes the terms and conditions of the applicant's policies and certificates. The form shall provide a clear, complete, and accurate description of the following, as applicable:

    a. Service area.

    b. Covered benefits, including, when applicable, a statement regarding prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

    c. Emergency health coverages and benefits.

    d. Out-of-area coverages and benefits.

    e. Explanation of the enrollee's financial responsibility for co-payments and any other out-of-pocket expenses.

    f. Provision for continuity of treatment in the event a provider's participation terminates during the course of an enrollee's treatment by that provider.

    g. Telephone number to call to receive information concerning grievance procedures.

    h. How the covered benefits apply in the evaluation and treatment of pain.

    i. Summary listing of the following information:

        (1) Current provider network in the applicant's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.
        (2) Professional credentials of participating health professionals.

(3) Licensing verification telephone number for the Department of Community Health.
(4) Prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.
(5) Indication of the financial relationships between the applicant and any closed provider panel.
(6) Provide a telephone number and address to obtain from the applicant additional information concerning the items described in the above subdivisions.

2. The subscriber contract shall address the following requirements contained in **Section 3523(3)(a-q)** of the Michigan Insurance Code:

a. Name and address of the organization.

b. Definitions of terms subject to interpretation.

c. Effective date and duration of coverage.

d. Conditions of eligibility.

e. Statement of responsibility for payments.

f. Description of specific benefits and services available under the contract within the service area, with respective co-payments and deductibles.

g. Description of emergency and out-of-area services.

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

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

j. Covenants of the subscriber shall address the following subjects:

(1) Timely payment.
(2) Non-assignment of benefits.
(3) Truth in application and statements.
(4) Notification of change in address.
(5) Theft of membership identification.

k. Statement of responsibilities and rights regarding the grievance procedure.

l. Statement regarding subrogation and coordination of benefits provisions, including any responsibility of the enrollee to cooperate.

m. Statement regarding conversion rights.

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

o. Provisions for grace periods for late payment.

p. Description of any specific terms under which the applicant or the subscriber can terminate the contract.

q. Statement of the non-assignability of the contract.

3. Each of the applicant's subscriber contracts shall address the following requirements contained in **Chapters 34** and **35** of the Michigan Insurance Code:

a. Policy cancellation (non-group). **(Section 3409)**

b. Grace period. **(Section 3410)**

c. Coinsurance for basic health services, excluding deductibles, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee and shall not be based on the provider's standard charge for the service. **[Section 3515(2)]**

4. The applicant's subscriber certificate shall include language describing the benefit mandates as required in **Chapters 34, 35** and **36** of the Michigan Insurance Code:

a. Prosthetic devices to maintain or replace body parts of an individual who has undergone a mastectomy. **[Section 3406a & 3613]**

a. Mental health services. **[Section 3406b & 3614]**

b. Hospice care **[Section 3406c & 3615]**

c. Breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services; coverage for breast cancer screening and mammography. **[Section 3406d & 3616]**

e. Drugs used in antineoplastic therapy and cost of its administration. **[Section 3406e & 3616a]**

f. Direct access by enrollee to an obstetrician-gynecologist. **[Section 3406m]**

g. Coverage for equipment, supplies and educational training for the treatment of diabetes. If outpatient pharmaceutical coverage is provided, include coverage for insulin, non-experimental medications for controlling blood sugar, and medications used in the treatment of diabetes related conditions. **[Section 3406p]**

h. A. health maintenance organization contract that provides pharmaceutical coverage shall provide coverage for an off-label use of a federal food and drug administration approved drug and the reasonable cost of supplies medically necessary to administer the drug. **[Section 3406q]**

i. Coverage for obstetrical and gynecological services provided by physician or nurse midwife. **[Section 3406r]**

j. Coverage for Diagnosis and treatment of autism spectrum disorders; coverage; coverage prohibition availability of other benefits; conditions; qualified health plan offered through American health benefit exchange pursuant to federal law; short-term or 1- time limited duration policy or certificate; prescription drug plan; coordinated benefits; definitions. **[Section 3406s]**

k. The subscriber contract shall, at a minimum, provide for the following basic health maintenance services. **[Section 3519(3)]:**

(1) Physician services including consultant and referral services by a physician, but not including psychiatric services. **[Section 3501(b)(i)]**
(2) Ambulatory services. **[Section 3501(b)(ii)]**
(3) Inpatient hospital services, other than those for the treatment of mental illness. **[Section 3501(b)(iii)]**
(4) Emergency health services. **[Section 3501(b)(iv)]**
(5) Outpatient mental health services, not fewer than 20 visits per year. **[Section 3501(b)(v)]**
(6) Intermediate and outpatient care for substance abuse. **[Section 3501(b)(vi)]**

(7) Diagnostic laboratory and diagnostic and therapeutic radiological services. **[Section 3501(b)(vii)]**
(8) Home health services. **[Section 3501(b)(viii)]**
(9) Preventive health services. **[Section 3501(b)(ix)]**
(10) To comply with PPACA requirement HMO subscriber contracts (individual or small group) must include all required essential health benefits.

5. The applicant's subscriber certificate shall include language addressing the following sections of the Michigan Insurance Code:

   (1) For retiree only group subscriber certificates: Hospital or medical care coverage or reimbursement for children who are full-time or part-time students and take leave of absence. **[Section 2264a]**

   (2) Legal actions. **[Section 3422]**

   (3) Optional provision addressing illegal occupation. **[Section 3452]**

6. The subscriber contract shall contain the requirements established by the Patient Protection and Affordability Care Act.

Provide a separate index identifying the section and page number where each of the above items is located in the subscriber contract.

Attachment 2

Health Maintenance Organization (HMO)
Alternative Health Care Financing and Delivery System (AFDS)

Grievance Documentation

Section 2213 of the Michigan Insurance Code, states that the grievance procedure shall meet the following requirements:

1. Provides for a designated person responsible for administering the grievance system and serving as the Office of Financial and Insurance Services' contact person.

2. Provides a designated person or telephone number for receiving complaints. Fax and e-mail would also be helpful, if available.

3. Ensures full investigation of a grievance.

4. Provides for timely notification to the enrollee as to the progress of an investigation.

5. Provides an enrollee the right to appear a designated person or committee to present a grievance.

6. Provides for notification in plain English to the enrollee of the results of the HMO's or AFDS' investigation and for advisement of the enrollee's right to request a review of the grievance by the Director or by an independent review organization under the Patient's Right to Independent Review Act. **(Sections 1901 to 1929)**

7. Provides a method for providing summary data on the number and types of complaints and grievances filed under this section. The insurer or health maintenance organization shall annually file the summary data for the prior calendar year with the director on forms provided by the director. (MCL 500.2213(1)(g).

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

9. Provides for copies of all complaints and responses to be available at the principle office of the HMO or AFDS for inspection by the Director for two years following the year the complaint was filed.

10. When an adverse determination is made, a written statement containing the reasons for the adverse determination will be provided to the enrollee along with written notifications as required under the Patient's Right to Independent Review Act. **(Section1907)**

11. That a final determination will be made in writing by the HMO or AFDS not later than 35 calendar days after a formal grievance is submitted in writing by the enrollee. The timing for the 35 calendar day period may be tolled, however, for any period of time the enrollee is permitted to take under the procedure and for a period of time that shall not exceed 10 business days if the HMO or AFDS has not received requested information from a health care facility or health professional.

12. That a determination will be made by the HMO or AFDS not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the enrollee may request a determination of the matter by an independent review organization under the Patient's Right to Independent Review Act. **(Section 1913).** If the determination by the HMO or AFDS is made orally, the HMO or AFDS shall provide a written confirmation to the enrollee not later than 2 business days after the oral determination.

13. That the enrollee has the right to a determination of the matter by the Director or his or her designee or an independent review organization under the Patient's Right to Independent Review Act. **(Sections 1901 to 1929).**