MODEL CONSUMER BLUE CROSS STATUTE

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§ 1 Short Title. This chapter shall be known and may be cited as the Hospital Service Corporation Act of 1973.

§ 2 Purposes. The legislature hereby finds that the citizens of this state have experienced large increases in the price of health care services and health care insurance coverage and that the continuing rise in such costs threatens their health and welfare by impairing their ability to obtain high quality, economical, and readily available health care. The legislature also finds that hospital service corporations are capable of working on behalf of subscribers to influence the cost and quality of the health care services rendered by contracting providers. The legislature further determines that hospital service corporations have both the ability and the duty to act as advocates of the public interest in the ready availability of high-quality, economical health care to all the citizens of this state. It is therefore the policy of this state to make hospital service corporations accountable and responsive to the public for the cost and quality of the health care services which they underwrite.

§ 3 Definitions. As used in this Act:

(1) "Commissioner" means the (Commissioner of Banking and Insurance).

(2) "Consumer" means a natural person who uses or potentially will use the services of a provider of health care; provided, however, that neither the consumer, nor the spouse of such consumer, is or ever has been any of the following: a physician; an administrator, employee, representative, trustee, or director on the board of a provider of health care; an administrator, employee, or representative of a hospital service corporation or a medical service corporation; a teacher, researcher, or planner of health and medical services; or a person with a substantial financial interest in a provider, a hospital service corporation, a medical service corporation, or a major vendor of goods and services to providers, hospital service corporations, or medical service corporations.

(3) "Health Care Provider" means any public or private facility which provides, on an inpatient or outpatient basis, preventive, diagnostic, therapeutic, convalescent, rehabilitation, mental health, or mental retardation services, including general and special hospitals, skilled nursing homes, extended care facilities, intermediate care facilities, and mental health centers.

(4) "Health Care Provider Contract" means a contract or arrangement entered into by a health care provider and a hospital service corporation wherein such provider agrees to provide specified services to subscribers or subscriber groups at specified rates of reimbursement.

(5) "Hospital Service Corporation" means a not-for-profit corporation organized under the laws of this state or doing business in this state for the purpose of establishing, maintaining and operating, solely for the benefit of the subscribers thereof, a nonprofit hospital service plan.

(6) "Medical Service Corporation" means a corporation as defined by (citation to "Blue Shield" statute).

(7) "Nonprofit Hospital Service Plan" means an arrangement whereby the expense of hospitalization or other health services rendered to subscribers of such plan by participating health care providers is paid or indemnified by the hospital service corporation.

(8) "Participating Health Care Provider" means a hospital or other health care provider, duly licensed or certified to provide hospital or other health care services under the laws of this state, which agrees in writing with the hospital service corporation to:

(a) provide services specified in the subscriber contracts issued by such corporation at such rates of compensation as shall be determined by said corporation's board of directors; and

(b) abide by those bylaws, rules, and regulations of such corporation as are applicable to participating health care providers.

(9) "Subscriber Contract" means a contract between a subscriber or a subscriber group and a hospital service corporation which sets forth the nature and scope of the services for which such corporation agrees to make payment to participating health care providers on behalf of the subscriber or subscriber group, or for which such corporation agrees to indemnify the subscriber or subscriber group, pursuant to a nonprofit hospital service plan.

(10) "Subscriber" means a person who has entered into a subscriber contract with a hospital service corporation under which he obtains specified coverage for health care services and costs in return for payment of specified rates.

(11) "Subscriber Group" means a group of persons (or the members thereof) which has entered into a subscriber contract with a hospital service corporation under which the members of the group obtain specified coverage for health care services and costs in return for payment of specified rates.

(12) "Rate" means the price or premium charged by a hospital service corporation to a subscriber or subscriber group for coverage under a nonprofit hospital service plan.

(13) "Rate of Reimbursement" means the amount of compensation to be paid by a hospital service corporation to a participating health care provider in compensation for the delivery of covered services to subscribers or subscriber groups.

§ 4 Permit to Engage in Business.

(1) No hospital service corporation shall operate a nonprofit hospital service plan or enter into a contract with a subscriber or subscriber group or with a health care provider until it has obtained a permit to engage in business under this Act. A hospital service corporation organized under the laws of another state or country shall not be licensed to do business in this state except as provided by (section on reciprocity) of this Act.

(2) Within 90 days of the effective date of this Act, every hospital service corporation shall submit to the Commissioner an application for a permit under subsection (3). Each such applicant may continue to operate until the Commissioner acts upon the application. In the event that an application is denied, the applicant shall henceforth be treated as a hospital service corporation doing business in this state without a permit to engage in business in this state.

(3) Each application for a permit to engage in business shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall set forth or be accompanied by the following:

(a) A copy of the basic organizational documents, and all amendments thereto, including the articles of incorporation and other applicable documents;

(b) A copy of the bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant;

(c) A list of the names, addresses, previous employment, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including the principal officers and the members of the board of directors, executive committee, or other governing board or committee;

(d) A list of the names, addresses, and salaries of all officers and other persons employed on a full-time basis by the applicant who are earning more than $20,000 per year before taxes, and of all officers and other persons employed on a part-time basis by the applicant who are earning the equivalent of $20,000 per year before taxes, accompanied by documentary evidence indicating that

(i) these persons are qualified to perform their employment responsibilities, and

(ii) the compensation for the services of such persons does not significantly exceed the compensation received by comparably qualified individuals having comparable employment responsibilities;

(e) A copy of any contract or other written agreement made or to be made between any hospital or other health care provider and the applicant;

(f) A copy of any contract made with or proposed to be offered to subscribers or subscriber groups;

(g) A schedule of all current and proposed rates of reimbursement to participating health care providers, and of all current and proposed rates to be charged to subscribers and subscriber groups, and all data relevant to the formulation of such rates.

(h) The applicant's most recent certified financial statement, audited by independent certified public accountants, showing the applicant's assets, liabilities, and income, and such other information in such form as the Commissioner shall prescribe;

(i) The applicant's financial planning projections, including expected trends in enrollment of subscribers or subscriber groups, utilization of the services of health care providers by subscribers and subscriber groups, costs of services of health care providers, rates of reimbursement to participating health care providers, and rates to be charged to subscribers and subscriber groups;

(j) A thorough description of the subscriber complaint procedures to be utilized in conformance with section 13 of this Act; and

(k) Such other information as the Commissioner shall deem necessary to the proper effective administration of this Act.

(4) A hospital service corporation shall file a notice describing any modification in any of the information required by subsection (3) with the Commissioner prior to such modification, or, if such prior notice is not practicable, within a reasonable time after such modification. If the Commissioner does not disapprove such modification within 60 days of its filing, it shall be deemed approved.

(5) Within 90 days of the receipt of an application for issuance of a permit to engage in business, the Commissioner shall determine whether to issue or deny said permit. Prior to making said determination, the Commissioner shall conduct an independent investigation of the applicant sufficient to verify the accuracy of the information submitted under subsection (3). No permit shall issue unless the Commissioner reasonably finds that:

(a) The composition of the applicant's governing body is consistent with the standards set forth in section 5;

(b) The persons responsible for the conduct of the affairs of the applicant are competent, qualified, trustworthy, and possess good reputations;

(c) The provisions of the applicant's existing or proposed subscriber contracts, including the schedule of rates to be charged to subscribers or subscriber groups and the nature and scope of the coverage of health care services, are consistent with the standards set forth in section 8;

(d) The provisions of the applicant's existing or proposed health care provider contracts, including the schedule of rates of reimbursement to such providers, are consistent with the standards set forth in section 10 of this Act;

(e) The applicant's existing or proposed complaint system is consistent with the standards set forth in section 13 of this Act;

(f) The applicant has given reasonable assurances that it will not engage in any activities prohibited under section 7 of this Act;

(g) The applicant is likely to make a vigorous, good-faith effort to make high-quality, economical hospital care available to its subscribers; and

(h) Nothing in the provisions or administration of the applicant's proposed non-profit hospital service plan, as shown by information submitted pursuant to subsection (3) or by independent examination on the part of the Commissioner, is contrary to the public interest.

(6) When the Commissioner has cause to believe that grounds for the denial of an application for a permit to engage in business exist, he shall notify such hospital service corporation in writing, specifically stating the grounds for denial and fixing a time thereafter for a hearing on the matter.

(7) Whenever the Commissioner has reasonable cause to believe that a hospital service corporation holding a permit to engage in business in this state is no longer in compliance with one or more of the standards set forth in subsection (5), he shall take such remedial action as he deems appropriate under the circumstances, including, but not limited to, suspension, conditional extension, or revocation of such permit.

§5 Governance.

(1) The Board of Directors or Trustees of a hospital service corporation shall comprise at least fifteen but not more than 25 members who shall be nominated and elected by the subscribers and subscriber groups of such corporation within one year of the effective date of this Act. Of the board members so elected, one third shall serve for a term of one year, one third for a term of two years, and one third for a term of three years. Thereafter, all board members shall serve for three-year terms, provided that no such member shall serve for more than two consecutive three-year terms. A vacancy occurring during a term shall be filled by the Board for the unexpired term. A majority of the Board shall constitute a quorum.

(2) The nomination and election of board members shall be conducted annually in a democratic manner which assures that the Board:

(a) is fairly representative of the age, sex, race, income, and residence characteristics of the total population of subscribers and subscriber groups of such hospital service corporation, and

(b) consists wholly of consumers.

(3) The members of the Board of Directors may obtain legal, actuarial, administrative, or other technical assistance from an advisory panel composed of representatives of health care providers and from the staff of the hospital service corporation.

§6 By-Laws.

Any amendments to by-laws of a hospital service corporation lawfully engaged in business in this state shall be submitted to the Commissioner at a reasonable time prior to their adoption. If the Commissioner finds that such proposed amendments would in part or in whole contravene the purposes or provisions of this Act, he shall so advise the Board of

Directors and the subscribers and subscriber groups of such corporation.

§7 Prohibited Activities.

No hospital service corporation or any of its agents or representatives may:

(1) Cause or knowingly permit the use of any advertising which is misleading, deceptive, or inconsistent with the responsibility of such corporation to promote high-quality, economical health care on behalf of its subscribers and subscriber groups;

(2) Contact, or urge its subscribers or subscriber groups or the public to contact, members of a legislative body for the purpose of proposing, supporting, or opposing legislation, including action by the Congress, by any state legislature, by any local council or similar governing body, or by the public in a referendum, initiative, constitutional amendment, or similar procedure;

(3) Purchase any services or goods valued at more than $1,000 without resort to competitive bidding conducted in accordance with rules and regulations promulgated by the Commissioner;

(4) Cancel or refuse to renew any subscriber contract except for failure to pay premiums;

(5) Sell subscriber contracts in such a manner as to mislead, deceive, or coerce any person into becoming a subscriber or member of a subscriber group; or

(6) Deposit or otherwise place revenues, reserves, or any other corporate funds into any account at any bank, savings and loan association, or similar institution which yields less than the maximum allowable rate of interest on such funds in such amounts, provided, however, that this prohibition shall not apply to those funds which the Commissioner reasonably deems necessary for the purpose of meeting day-to-day operating cash needs.

§8 Subscriber Contracts.

(1) No hospital service corporation shall enter into any contract with any of its subscribers or subscriber groups until a copy of

(a) the proposed contract,

(b) the full schedule of rates to be paid by the contracting subscriber or subscriber group, and

(c) the full schedule of the health care services for which the contracting subscriber or subscriber group is to be covered

shall have been filed with and approved by the Commissioner. Within 90 days of the filing of such information, the Commissioner shall approve or

disapprove the form and provisions of the contract, including the rates to be charged, and the nature and scope of the health care services to be covered.

(2) The Commissioner shall not approve any subscriber contract which fails to present all material items of information concerning the coverage available to the subscriber or subscriber group thereunder in a manner which is clear, concise, and intelligible to all subscribers, or which contains any statement or item of information that is untrue or misleading, or which is deceptive.

(a) An item of information shall be deemed to be material if it is necessary to enable a reasonable person, not possessing special knowledge regarding health care coverage, to make a rational, informed choice as to whether or not to enter into or renew a subscriber contract.

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

(c) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to a subscriber to, or a person considering subscribing to, a non-profit hospital service plan, if such benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

(d) A subscriber contract shall be deemed to be deceptive if said contract, taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding non-profit hospital service plans, to expect benefits, services, charges, or other advantages which the subscriber contract does not provide or which the non-profit hospital service plan issuing such subscriber contract does not regularly make available to subscribers or subscriber groups.

(3) The Commissioner shall approve no schedule of rates to be charged to subscribers or subscriber groups which he deems unreasonable, unfair, or unduly discriminatory.

(a) Rates to be charged to subscribers or subscriber groups shall be deemed unreasonable if the Commissioner finds that the hospital service corporation has failed to make a vigorous, good-faith effort to contain rates of reimbursement to hospitals and other participating health care providers.

(b) Rates to be charged to subscribers or subscriber groups shall be deemed unfair if the Commissioner, taking into consideration the non-profit and tax-exempt status of the hospital service corporation, finds that such corporation has failed to fulfill, to the maximum extent feasible, its duty to make available to all citizens of this state,

regardless of income, residence, or health status, the opportunity to obtain adequate coverage for health care services.

(c) Rates to be charged to subscribers or subscriber groups shall be deemed unduly discriminatory if the Commissioner finds that the actuarial formulas to be used in such experience rating schedule or the classifications of subscriber groups to which such experience rating schedules are to apply would be likely to prejudice the interests of either:

(i) subscribers or subscriber groups whose rates are not subject to such experience rating schedules, or

(ii) persons of poor health status seeking to become subscribers or members of community-rated subscriber groups.

No schedule of experience-based rates shall be approved by the Commissioner unless the applicable actuarial formula provides that subscriber groups so rated will be assessed a reasonable community service charge.

(d) For the purpose of making his determinations under this subsection, the Commissioner shall examine and consider all data relevant to such rate schedules prepared and submitted by such corporation in such form and at such time as he shall prescribe.

(4) The Commissioner shall approve no subscriber contract unless he finds that such contract:

(a) Provides health care service coverage sufficiently comprehensive in scope, amount, and duration to afford subscribers adequate protection against the costs of high-quality health care delivered in all appropriate medical settings, including coverage for inpatient and outpatient hospital services, emergency health services, diagnostic laboratory and diagnostic and therapeutic radiologic services and preventive health services;

(b) Provides health care service coverage at a reasonable expense ratio;

(c) Provides benefits that are reasonable in relation to the premiums charged;

(d) Contains no coverage or benefits so limited as to be of no substantial economic value to the subscriber or subscriber group;

(e) Contains no exclusions, conditions, limitations, or reductions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of such contract;

(f) Offers coverage on the basis of service benefits rather than fixed dollar benefits to the extent necessary to provide subscribers and subscriber groups with open-ended protection which responds to changing medical procedures and technology;

(g) Provides family plan coverage without regard to marital status;

(h) Provides coverage of abortion services as minor surgery;

(i) Provides coverage of pre-admission testing on an outpatient basis;

(j) Provides coverage on both an outpatient and inpatient basis for all services which, consistent with sound medical practice, can be rendered on either an outpatient or inpatient basis;

(k) Provides, in the case of a contract with a subscriber group, conversion privileges whereby persons no longer eligible for coverage under such contract may obtain substantially similar individual coverage and benefits;

(l) Provides for reasonable open enrollment periods on an annual or semi-annual basis, whereby individuals are accepted for coverage without regard to age, race, sex, residence, or health status;

(m) Sets forth the rights of a subscriber as a patient pursuant to section 11 and the rules and regulations promulgated thereunder; and

(n) Describes the rights of the subscriber under such corporation's complaint system established pursuant to section 13.

(5) At least 30 days prior to the approval or disapproval of a subscriber contract pursuant to subsection (1), the Commissioner shall cause notice of the provisions of such proposed contract to be given to the public and to any person or group of persons who has listed a name and address with the Commissioner for the purpose of such notification. The public shall have the right to examine all information offered in support of such proposed contract and shall have the right to file written objections thereto within 30 days of notice of such proposed approval. Prior to the approval of such proposed contract, the Commissioner shall respond, in writing, to the objections filed thereto, with a reasoned statement supporting his decision to accept or reject such objections to such proposed contract. All such written objections, and the Commissioner's responses thereto, shall be available for public inspection.

(6) If at any time the Commissioner has cause to believe that a subscriber contract or the parties thereto are no longer in compliance with subsection (3) and (4), the Commissioner may withdraw his approval of such contract after a public hearing, of which not less than 10 days' written notice shall have been given to the public and to the parties thereto. It shall be unlawful for a hospital service corporation to utilize such subscriber contracts after the effective date of such withdrawal of approval.

(7) In approving, disapproving, or withdrawing his approval for a subscriber contract under this section, the Commissioner shall specify in writing the reasons therefore.

§9 Subscriber Rate Increases.

(1) No proposed increase in the rates charged to subscribers or subscriber groups shall take effect until a full schedule of such proposed rate increase has been filed with and approved by the Commissioner. Such proposed rate increase must be adequately supported by documentation as to its necessity and evidence that the applicant hospital service corporation is in full compliance with section 10 (2) of this Act. For purposes of this section, a proposed increase in the rates charged to subscribers or subscriber groups shall include any proposed increase in the premium or co-payments, to be charged, restriction in coverage, increase in deductible level, or any similar proposed reduction in benefits to subscribers or subscriber groups without a corresponding reduction in rates.

(2) The Commissioner shall examine, on a sample or other basis, the accuracy of the documentation and evidence submitted by such corporation pursuant to subsection (1). Such corporation shall afford the Commissioner, or his appointed delegate, ready and convenient access to all data upon which such documentation and evidence are based.

(3) At least 30 days prior to making a determination under subsection (7), the Commissioner shall cause notice of the terms of such proposed subscriber rate increase to be given to the public, to the affected subscriber or subscriber group, and to any person or group of persons who has listed a name and address with the Commissioner to be so notified. The public shall have the right to examine all information offered in support of such proposed rate increase and shall have the right to file written objections thereto within 30 days of such notice. Prior to the approval of such proposed rate increase, the Commissioner shall respond, in writing, to the objections filed thereto, with a reasoned statement supporting his decision to accept or reject public objections to such proposed rate increase. All such written objections, and the Commissioner's responses thereto, shall be available for public inspection.

(4) Prior to approving any proposed subscriber rate increase, the Commissioner shall, upon 10 days' notice, conduct a public hearing at which representatives of such hospital service corporation shall appear and respond to any written objections to such proposed rate increase filed with the Commissioner, and at which the public, including subscribers and representatives of subscriber groups affected thereby, shall have an opportunity to be heard.

(5) The Commissioner shall approve, deny, or modify any such proposed rate increase in accordance with the standards set forth in section 8 (3).

§10 Health Care Provider Contracts.

(1) No health care provider contract entered into by a hospital service corporation with any health care provider shall take effect without prior approval by the Commissioner. Applications for such approval shall be made in such form as the Commissioner shall prescribe. The Commissioner may approve or disapprove such contract.

(2) The Commissioner shall not approve any such contract which fails to evidence a good-faith effort by the hospital service corporation to promote the purposes of this Act as set forth in section (2). The Commissioner shall disapprove any contract which contains payments for:

(a) The provision of services or items which are not medically necessary;

(b) The provision of services or items on an inpatient basis which, consistent with sound medical practice, could effectively have been provided on an outpatient basis or more economically in an inpatient health care facility of a different type;

(c) Profits to non-profit hospitals, plus factors, or other charges not related to direct actual costs;

(d) Services, supplies, or equipment at prices in excess of current market rate which would be paid by a cost-conscious purchaser;

(e) Research or education costs not directly and identifiably related to the care of a particular subscriber patient;

(f) Dispensation of brand-name drugs where less expensive generic drugs of equivalent therapeutic effect are available;

(g) Expenses related to facilities constructed without the prior approval of the appropriate Areawide Comprehensive Health Planning Agency established pursuant to section 314(b) of P.L. 89-749, including, but not limited to, capital, depreciation, interest on borrowed funds, return on equity capital (in the case of proprietary facilities), maintenance, and operating costs.

(h) Salaries, fees, or other compensation of those persons employed on a full-time, part-time, or consultant basis by a health care provider who are earning more than the equivalent of $20,000 before taxes on an annualized basis where such health care provider has failed to submit adequate evidence that (i) said person is qualified to perform the responsibilities for which he is being compensated and (ii) no equally or more qualified persons are available to perform such responsibilities at a lower rate of compensation; or

(i) Membership in civic or political organizations, provided, however, that this subsection shall not be deemed to prohibit a health care provider from receiving payments for reasonable expenses incurred in connection with accreditation by the Joint Commission on Accreditation of Hospitals, membership in the American Hospital Association, and membership in one state and one local hospital association at nominal cost;

(3) The Commissioner shall not approve any such contract between a hospital service corporation and any health care provider which, in its delivery of health care, does not observe, protect, or promote the rights of patients as set forth in section 11 of this Act, or which, in the composition of its governing body, does not provide for significant consumer participation.

(4) At least once every two years, such hospital service corporation shall renegotiate rates of reimbursement paid to each parti-

cipating health care provider. The Commissioner, or his designated representative, may be a party to such negotiations and shall have full and convenient access to all information relevant to the negotiations in the possession of the parties thereto. All such negotations shall at all times be open to the public, and adequate notice thereof shall be given to the public, to subscribers, and to subscriber groups. The Commissioner may cause minutes of such negotiating sessions to be recorded. A transcript of any such minutes, and all documents used in connection with such negotiations, shall be made available to the public for inspection.

(5) Whenever the Commissioner determines that participating health care providers have incurred costs which were not and could not have been anticipated in such contract, and which could not reasonably have been avoided without risk of jeopardy to the quality of health care services rendered by such provider, he may approve, on a retroactive basis, an adjustment in the rates which adequately compensates for such unanticipated and unavoidable costs; provided, that in no case shall the Commissioner approve any such adjustment the effect of which is to provide compensation to such provider in excess of the unanticipated and unavoidable costs actually incurred by such provider.

§ 11 Patient's Rights.

Health care providers in this state shall provide health care in a manner consistent with the dignity of each patient as a human being. In rendering health care, such providers shall take all reasonable measures to observe, protect, and promote:

(1) The right of each patient to care considerate and respectful of his personal dignity at all times, including, but not limited to, the right to be treated without discrimination based on race, religion, sex, national origin, ability to pay or source of payment.

(2) The right of each patient to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms that such patient can reasonably be expected to understand. When, in extreme circumstances, it is not medically advisable to give such information to such patient, the specific medical reasons supporting such decision to withhold information shall be noted in such patient's medical record, and such information shall be made available to an appropriate person in his behalf.

(3) The right of each patient to know, by name, each person providing care to him, including the physician responsible for coordinating his care.

(4) The right of each patient to be informed by any medical student participating in such patient's care of the student status of such student at the time of such participation.

(5) The right of each patient to full information as to any relationship between the health care provider from whom he is receiving care and any other health care providers or educational institutions insofar as his care is concerned, including information as to the existence of any

professional relationships among individuals, by name, who are treating him and information as to the presence of any conflict of interest which arises at any time during the course of a patient's treatment.

(6) The right of each patient to have the person responsible for his care obtain his informed consent at a reasonable time prior to the initiation of any procedure or treatment affecting such patient, except in emergency circumstances where such consent cannot practicably be obtained without substantial threat to the patient's well-being. For purposes of this Act, "informed consent" shall mean voluntary, autonomous assent, without duress, to the initiation of a proposed procedure or treatment, given on the basis of an adequate understanding of all information relevant to such a determination. Such information shall include, but not necessarily be limited to, the diagnosis; the specific procedure or treatment; the name of the person responsible for such procedures or treatment; such person's experience with such procedures or treatment; the major and collateral short-and long-term risks, and the pain and discomfort, attendant to such procedure or treatment; the benefits and probable duration of incapacitation anticipated from such procedure or treatment; the prognosis; and any medically significant alternative methods for treatment, and the risks and benefits attendant thereto. Each patient lacking sufficient maturity or mental capacity to formulate the judgment requisite for the exercise of informed consent shall have the right to a fair and timely process which, to the maximum extent feasible, gives full force and effect to his right to have the persons responsible for his care obtain his informed consent under this sub-section.

(7) The right of each patient to be advised if the health care provider or any of the physicians participating in his care proposes to engage in or perform human experimentation or research affecting his care or treatment, and the right of each patient to refuse to participate in such experimentation or research and to terminate any participation in such experimentation or research at any time.

(8) The right of each patient to refuse treatment, except in the case of communicable diseases or where otherwise contrary to law, and to be fully informed of the medical consequences of his action.

(9) The right of each patient to every consideration of his privacy concerning his own medical care program, including, but not limited to, case discussion, consultation, examination, diagnosis, and treatment. Those not directly participating in such patient's care, including medical students, must obtain the consent of the patient to be present at any case discussion, consultation, examination, diagnosis, or treatment involving such patient.

(10) The right of each patient to have all communications and records pertaining to his care treated as confidential.

(11) The right of each patient to have ready and convenient access to all communications and records pertaining to his care. When, in extreme circumstances, it is not medically advisable for a health care provider to make such communications or records available to such patient, the specific medical reasons supporting such decision to withhold information shall be noted in such patient's medical record, and such information shall be made available to an appropriate person acting on his behalf.

(12) The right of each patient to a reasonable response from any health care provider to a request for services by him or on his behalf. Such health care provider shall provide evaluation, service, and/or referral, as indicated by the urgency of the case; provided, however, that any patient in immediate need of inpatient medical treatment has the right to admission at such health care provider regardless of ability to pay for such treatment. When medically permissible, a health care provider may transfer a patient to another health care provider, but only after such patient has received complete information and explanation concerning the need for and alternatives to such transfer. No such transfer may occur unless and until the health care provider to which such patient is to be transferred has accepted such patient for transfer. The health care provider transferring such patient shall remain fully responsible for the care and treatment of such patient until such time as the patient is physically admitted by the health care provider to which he is transferred.

(13) The right of each patient to reasonable continuity of care; to know in advance the availability of appointment times and physicians; and to receive information from his physician or a delegate of his physician concerning his continuing health care requirements subsequent to discharge.

(14) The right of each patient to full and frank disclosure of the fact that he has received poor quality care and the medical consequences thereof, at such time that it becomes known or should have become known that he has received poor quality care.

(15) The right of each patient to timely and effective redress of his grievances concerning any aspect of his care or treatment or any failure to observe, protect or promote his rights as enumerated in this section, through a fair and expeditious administrative process which shall, at a minimum, make provision for a patient advocate and adequate support personnel, directly accountable to the patient, and a system whereby the action taken on each complaint is summarized in writing and made available to the complainant and the Commissioner.

(16) The right of each patient, regardless of source of payment, to examine and receive a detailed explanation of his total bill for services rendered by his health care provider, including the itemized charges for specific services received.

(17) The right of each patient to adequate counseling and other aid from a health care provider in obtaining financial assistance from public or private sources to meet the expense of services received or to be received from such provider.

(18) The right of each patient to timely, prior notice of the termination of his eligibility for reimbursement for the expense of his care by a third-party payor.

(19) The right of each patient to be advised, in a timely and comprehensible fashion, of his rights as enumerated in this section and of the rules and regulations of the health care providers.

Within one hundred eighty (180) days of the enactment of this Act, the Department of Health, after public notice and hearing, shall promulgate such rules and regulations as are necessary to effectuate the purposes and provisions of this section.

§12 Limitation on Liability of Subscribers.

(1) Where (a) a hospital service corporation determines that payment may not be made under the terms and conditions of an approved health care provider contract for any expenses incurred for items or services furnished a subscriber by a participating health care provider covered by such contract, and (b) both such subscriber and such health care provider, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such non-profit hospital service plan, then, notwithstanding such determination, payment shall be made to such participating health care provider for such items or services.

(2) In each such case, such corporation shall notify both the health care provider and the subscriber of the conditions under which payment for such items or services was made.

(3) In the case of comparable situations arising thereafter with respect to such subscriber or such health care provider, each shall, by reason of such notice, be deemed to have knowledge that payment shall not be made for such items or services or reasonably comparable items or services.

(4) Where a hospital service corporation denies claims for payment, the affected subscriber shall have the right to notice and appeal under the complaint system established and operated by such corporation pursuant to section 13.

(5) Where such corporation finally denies payment for services rendered to a subscriber by a participating health care provider, both such subscriber and such provider shall have a right to appeal such determination within 60 days to a Claims Arbitration Board composed of one representative of such corporation, one representative of such provider, and one member selected by such representatives. If such representatives fail to select such member within a reasonable period of time, such member shall be named by a disinterested party designated by the Commissioner.

(6) The Claims Arbitration Board shall conduct a formal hearing as to the matters appealed, and within 60 days of the close of the hearing, forward its adjudication to the parties thereto and to the Commissioner. The adjudication shall be in writing and signed by a majority of the members of the Board hearing such appeal. The costs of such appeals proceedings shall be apportioned equally between the parties thereto.

(7) Within 30 days after receipt of such Board's adjudication, any party aggrieved thereby shall have the right to appeal such adjudication

to the appropriate court of competent jurisdiction, which shall hear the case de novo.

(8) A final determination on such appeals shall be binding and shall constitute a bar to any action by such health care provider against such subscriber for payment for services rendered.

§13 Subscriber Grievances.

(1) Every hospital service corporation shall establish and maintain a complaint system, subject to the approval of the Commissioner, which affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by subscribers or prospective subscribers concerning any matter relating to the provisions of the subscriber contracts other than rates, including, but not limited to, claims for reimbursement; denials, cancellations, or non-renewals of such contracts; and the quality of the services delivered by participating health care providers.

(2) The hospital service corporation shall give a timely and reasoned response, in writing, to each written complaint it receives. Copies of such complaints and responses shall be made available to the Commissioner and to the public for inspection.

(3) Every hospital service organization shall submit to the Commissioner an annual report, in such form as prescribed by the Commissioner, which describes the complaint system and includes a compilation and analysis of the complaints filed, their disposition, and their underlying causes.

§14 Reports.

(1) Every hospital service corporation shall, on or before the first day of __________ of each year, file with the Commissioner a financial statement, verified by at least two of its principal officers and audited by an independent certified public accountant, showing its financial condition on the thirty-first day of December then next preceding, which shall be in such form and contain such information as the Commissioner shall by rule prescribe.

(2) The Commissioner may require participating health care providers to submit periodic reports containing data relating to such non-profit hospital service plan in which such providers participate, including, but not limited to, data regarding patient intake and discharge, in such form and with such frequency as the Commissioner shall prescribe.

§15 Examinations.

(1) The Commissioner may examine the affairs of any hospital service corporation and any health care providers with whom such corporation has

entered into contracts, agreements, or other arrangements pursuant to its non-profit hospital service plan as often as he deems it necessary for the protection of the interests of subscribers and the citizens of this state, but at least once every 3 years.

(2) The Commissioner, or his designated representative, shall have the power of visitation and examination into the affairs of any such corporation or provider. Every such corporation and provider shall submit its books, records, and other documents relating to its non-profit hospital service plan to, and in every way facilitate, such examinations. For the purpose of such examinations, the Commissioner may summon, and qualify and examine under oath, the officers and agents of such corporation and the principals of such providers concerning their affairs.

(3) In conducting any examinations under this section, or any other investigations or examinations authorized by this Act, including those under subsections 4(5), 8(3)(d), and 9(2), the Commissioner may employ competent, independent, disinterested experts to assist him in making these determinations, including attorneys, actuaries, accountants, health economists, and administrative science specialists. The costs of such expert services shall be assessed against such corporation but shall not annually exceed an amount equal to _____ per cent of the sum of premiums earned plus net realized investment gain or loss of such corporation, as reflected in the most current financial statement on file with the Commissioner.

§16 Investments; Reserves.

(1) No hospital service corporation shall invest in any securities other than those permitted as investments of (domestic life insurance companies) in this state pursuant to (citation to appropriate statutory provision).

(2) No hospital service corporation shall invest in any real property other than that which, subject to the approval of the Commissioner, can be reasonably expected to be required for the principal office of such corporation and other accommodations reasonably necessary to the transaction of business, but in no event shall such investment exceed ________ per cent of the net premium income of such corporation.

(3) Every hospital service corporation shall maintain a statutory reserve fund which shall from time to time during each calendar year be increased in an amount equal to at least one (1) per cent of the net premium income of such corporation during such whole calendar year, provided that the statutory reserve fund at the end of any calendar year shall not exceed five (5) per cent of the net premium income of such corporation for such calendar year.

(4) Notwithstanding the prohibitions contained in subsections (2) and (3), a hospital service corporation may, subject to the approval of the Commissioner, apply up to the amount accrued in the statutory reserve

fund at the end of any calendar year toward:

(a) The development and construction of ambulatory care facilities approved by the appropriate area-wide comprehensive health planning agency established pursuant to section 314(b) of P.L. 89-749, whether or not such facility is operated solely for the benefit of subscribers or subscriber groups; and

(b) The development, establishment, management, or promotion of a prepaid comprehensive health maintenance organization as defined in (citation to state HMO enabling legislation), whether or not such facility is operated primarily for the benefit of subscribers or subscriber groups.

The Commissioner shall approve no investment or other application of funds from statutory reserve fund under this subsection without giving full consideration to the risk involved in the proposed venture, the recommendation of the appropriate area-wide comprehensive health planning agency as to the need for the proposed venture, the risk characteristics of investments outstanding, and the interests, if any, of subscribers of such corporation in the maintenance of an adequate statutory reserve fund.

§17 <u>Penalties and Enforcement</u>.

(1) If the Commissioner shall for any reason have cause to believe that any violation of any provision of this Act has occurred or is threatened, he may hold a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation. Such proceedings shall not be governed by any formal procedural requirements, and may be conducted in such manner as the Commissioner may deem appropriate under the circumstances.

(2) The Commissioner may issue an order directing a hospital service corporation or a participating health care provider to cease and desist from engaging in any act or practice in violation of the provisions of this Act. Within _____ days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this Act have occurred.

(3) In the case of any violation of the provisions of this Act, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (2), the Commissioner may:

(a) In lieu of suspension, conditional extension, or revocation of a permit to engage in business under section 4(7), levy an administrative penalty in an amount not less than $100 nor more than $1000, if reasonable notice in writing is given of intent to levy the penalty and the violator has had a reasonable time within which to remedy the conditions which gave rise to the penalty;

(b) Augment any administrative penalty by an amount equal to the sum that he calculates to represent the damages suffered by subscribers or other members of the public; and

(c) Institute a proceeding to obtain injunctive relief, or seek other appropriate relief, in the (name of the court of primary jurisdiction).

(4) The enforcement powers conferred on the Commissioner in this section shall not be deemed to restrict or extinguish any concurrent rights of subscribers to invoke judicial or administrative relief from any violations of the provisions of this Act.

§18 Regulations.

The Commissioner may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the purposes and provisions of this Act.

§19 Administration.

The Commissioner shall administer the provisions of this Act in accordance with the purposes of this Act as set forth in section 2.

§20 Freedom of Information.

The public shall have ready and convenient access to all applications, submissions, filings, papers, reports, memoranda, documents, and all other information developed in connection with the administration of this Act, including all information arising from any examination, investigation, hearing, or negotiation conducted pursuant to this Act.

§21 Citizen Actions.

(1) Except as provided in subsections (2) and (3), any consumer may commence a civil action in his own behalf against:

(a) Any hospital service corporation or health care provider which is alleged to be in violation of (i) any provision of this Act or (ii) an action taken by the Commissioner or the(Secretary of the Department of Health) with respect to any provision of this Act; or

(b) The Commissioner (or the (Secretary)), where there is alleged a failure of the Commissioner (or the (Secretary)), to perform any act or duty under this Act which is not discretionary with him.

(2) No action may be commenced under subsection (1)(a):

(a) Prior to 10 days after the plaintiff has given notice of

the violation (i) to the Commissioner (or the (Secretary)) and (ii) to any alleged violator of the provision or order; or

(b) If the Commissioner (or the (Secretary)) has commenced and is diligently prosecuting an action to require compliance with the provision or order, but in any such action by the Commissioner (or the (Secretary)), any consumer may intervene as a matter of right.

(3) No action may be commenced under subsection (1)(b) prior to ten (10) days after the plaintiff has given notice of such action to the Commissioner (or the (Secretary)).

(4) In any action brought under subsection (1)(a) of this section, the Commissioner (or the (Secretary)), if not a party, may intervene as a matter of right.

(5) The (name of court of competent jurisdiction) shall have jurisdiction to enforce such provision or such order, or to order the Commissioner (or the (Secretary)) to perform such act or duty, as the case may be.

(6) The (court), in issuing a final order, decree, or other final determination in any action brought under this section, shall, if the plaintiff prevails, award such plaintiff the full costs of litigation (including reasonable attorney and expert witness fees) to be paid by the defendant in such action.

(7) Nothing in this section shall be deemed to restrict or extinguish any concurrent rights of subscribers to invoke judicial or administrative relief from any violations of the provisions of this Act.

NOTE

Provisions dealing with the following areas of concern have been omitted from this bill: tax-exempt status of hospital service corporations; merger of hospital services, medical service, and dental service corporations; rehabilitation, liquidation, or conservation of hospital service corporations; reciprocity with foreign corporations; administrative procedures; judicial review; relationship to other laws; and severability.

Since there is not really a model consumer approach to these "nuts and bolts" issues, the task of drafting such provision has been left to consumer advocates familiar with local law and practice.

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