

HEALTH LAW FOCUS

MICHIGAN SUPPLEMENT

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TEN THINGS YOU SHOULD KNOW ABOUT THE RECENT CHANGES IN MICHIGAN HMO REGULATIONS

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By now all plans licensed as health maintenance organizations should be aware that new laws, effective June 29, 2000, placed them under the Insurance Division of the Office of Financial and Insurance Services for regulatory purposes. Even though summaries and seminars abound to assist HMOs with the transition, many issues under the new regulatory scheme might escape notice until problems arise. What follows are ten items to pay attention to now for planning purposes.

1. Audited financial statements must be produced following Statutory Accounting Principles (SAP). Previously, statements prepared according to Generally Acceptable Accounting Principles (GAAP) were allowed with a reconciliation to SAP. Take the time now to plan for this change during the preparation phase for the annual audit.
2. If the HMO has not done so, it must register the name of its public accountant or public accounting firm with the commissioner at the Insurance Division in writing. This requirement did not previously apply to HMOs. Registration should have occurred within 60 days of June 29, 2000. The HMO also must obtain a letter from its public accountant stating that he or she is aware of and

will comply with the insurance code's provisions and the rules and regulations that relate to accounting and financial matters. A copy of this letter needs to be provided to the commissioner as well. Be aware that there are specific short time frames for reporting changes in the choice of public accountant or public accounting firm to the commissioner.

3. The new law sets out specific requirements for the qualifications of the independent public accountant that audits an HMO. One of the requirements is that an individual public accountant or a partner for the auditing firm may conduct the annual audit for no more than seven consecutive years. This may pose a problem for HMOs choosing regional firms or local public accounting offices if they are too small to accommodate this requirement.
4. The annual statement for HMOs is now due on March 1, rather than March 31, each year. With heightened scrutiny anticipated by new regulation, this year is a good year to have the annual statement reviewed by legal counsel, with particular attention paid to the General Interrogatories to ensure that the HMO has an accurate baseline statement under the new regulatory framework.
5. The audited financial statements are now due June 1, rather than March 31 each year.
6. HMOs are now subject to many other filing requirements under the insurance code, most notably the Form filings required for transactions

with affiliates. The definitions of affiliate and control are quite broad. Management arrangements are encompassed within the meaning of control. A Form A must be filed when there is a change of control. For example, if an HMO wants to acquire another HMO's book of business, prior approval must be obtained from the commissioner by filing a Form A. Forms B and C are annual filings, due May 1, providing information about affiliated parties. Form D is required to give the Insurance Division prior notice of any affiliated transaction, such as service agreements and loans between affiliates. Failure to file a required Form can result in fines. Corporate structure and management agreements should be reviewed now to determine if the Form filing requirements apply.

7. HMOs may no longer do business under an assumed name. All documents, from the certificate of authority to the evidences of coverage, must be in the company's incorporated name. When reprinting documents to comply with this requirement, remember to include that the HMO is now regulated by the Insurance Division.
8. HMOs will be reprinting evidences of coverage because the new Patient Right to Independent Review Act provides all commercial enrollees, and possibly Medicare and Medicaid enrollees, who

have received an adverse determination with an external review by an independent review organization. As of October 1, 2000, the independent review process became operational.

9. Employment contracts for any officer, director, or salaried employee cannot extend beyond twelve months. If contracts for longer periods of time are currently in use, they need to be amended to reflect the shorter twelve month time frame. Automatic renewal for twelve month periods, if not terminated according to the terms of the contract, should be acceptable.
10. HMOs are required to hold and maintain legal title to all of their assets. This includes cash and investments. HMO assets and funds cannot be commingled with those of another entity (e.g., an affiliate's) assets and funds. This requirement applies to pooling or cash management type arrangements. Now is a good time to review asset management arrangements and make changes prior to the year-end audit.

This list is by no means exhaustive. There are many aspects of the new laws to be incorporated into HMO operations. Health maintenance organizations should confer with legal counsel to ensure compliance with these laws and regulations.