

**§ 58-67-35. Powers of health maintenance organizations.**

(a) The powers of a health maintenance organization include, but are not limited to the following:

- (1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization;
- (2) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;
- (3) The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;
- (4) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;
- (5) The contracting with an insurance company licensed in this State, or with a hospital or medical service corporation authorized to do business in this State, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;
- (6) The offering and contracting for the provision or arranging of, in addition to health care services, of:
  - a. Additional health care services;
  - b. Indemnity benefits, covering out-of-area or emergency services;
  - c. Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or hospital or medical service corporations; and
  - d. Point-of-service products, for which an HMO may precertify out-of-plan covered services on the same basis as it precertifies in-plan covered services, and for which the Commissioner shall adopt rules governing:
    1. The percentage of an HMO's total health care expenditures for out-of-plan covered services for all of its members that may be spent on those services, which may not exceed twenty percent (20%);
    2. Product limitations, which may provide for payment differentials for services rendered by providers who are not in an HMO network, subject to G.S. 58-3-200(d).
    3. Deposit and other financial requirements; and
    4. Other requirements for marketing and administering those products.

- (b) (1) A health maintenance organization shall file notice, with adequate supporting information, with the Commissioner prior to the exercise of any power granted in subsections (a)(1) or (2). The Commissioner shall disapprove such exercise of power if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the

Commissioner does not disapprove within 30 days of the filing, it shall be deemed approved.

- (2) The Commissioner may promulgate rules and regulations exempting from the filing requirement of subdivision (1) those activities having a de minimis effect. (1977, c. 580, s. 1; 1979, c. 876, s. 1; 1991 (Reg. Sess., 1992), c. 837, s. 8; 1997-519, s. 3.18; 2001-334, s. 8.2.)