(B) Is provided with an effective incentive to avoid unnecessary inpatient utilization, regardless of whether the individual physician members of the group are paid on a fee-for-service or other basis; and

(4) Assures to its subscribers and members, the Commissioner, and the Department of Health and Mental Hygiene that one clearly specified legal and administrative focal point or element of the organization is charged with the responsibility of providing the availability, accessibility and quality (including effective utilization) of comprehensive health care services.

(f) ["Person"] "ORGANIZATION" means any individual, partnership, association, corporation, or other legal entity.

(g) ["Health care plan" (which may be referred to as a "benefit package")] "BENEFIT PACKAGE" means ~~the arrangement through which health care services are~~ A SET OF HEALTH CARE SERVICES TO BE provided to a member under contracts which entitle the member to the health care services provided directly, or furnished through contracts or arrangements with other persons, by a health maintenance organization.

844.

(a) The Commissioner shall issue a certificate of authority, within 90 days of the filing of the application, to any organization filing an application in conformity with § 843, upon payment of the prescribed fees, upon receipt of official written notification from the Department of Health and Mental Hygiene that the organization's proposed health related services, operations and functions falling under the regulatory jurisdiction of the Department appear to meet its requirements or have been approved by the Department, and upon being satisfied that:

(1) The organization proposes to establish and operate a bona fide health [care plan] MAINTENANCE ORGANIZATION having the capability to provide health care services in the geographic area proposed;

(2) The proposed health [care plan] MAINTENANCE ORGANIZATION is actuarially sound and the organization has an adequate schedule of minimum tangible net equity. These requirements may be satisfied by a finding that the organization has made acceptable arrangements to provide all or stipulated parts of health care services offered;

(3) The terms of contracts, including any medical assistance program contracts under "Subchapter XVIII. — Health Insurance for the Aged and Disabled" (Medicare) 42 U. S. C. § 1395 et seq. (1970 Ed. and Supp. III 1972), as amended from time to time, [and] "Subchapter XIX. — Grants to States for Medical Assistance Programs"