HOUSE BILL No. 5197

September 27, 1991, Introduced by Rep. Fitzgerald and referred to the Committee on Insurance.

A bill to amend sections 301, 407, 502, 506, 508, 509, 510, 511, and 513 of Act No. 350 of the Public Acts of 1980, entitled "The nonprofit health care corporation reform act," section 301 as amended by Act No. 45 of the Public Acts of 1988 and section 502 as amended by Act No. 38 of the Public Acts of 1988, being sections 550.1301, 550.1407, 550.1502, 550.1506, 550.1508, 550.1509, 550.1510, 550.1511, and 550.1513 of the Michigan Compiled Laws; and to add sections 402b, 402c, 403b, 403c, 403d, 403e, 405a, 405b, 407a, 407b, 407c, 407d, and 408a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 301, 407, 502, 506, 508, 509, 510, 511, and 513 of Act No. 350 of the Public Acts of 1980, section 301 as amended by Act No. 45 of the Public Acts of 1988 and section 502 as amended by Act No. 38 of the Public Acts of 1988, being sections 550.1301, 550.1407, 550.1502, 550.1506, 550.1508,

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550.1509, 550.1510, 550.1511, and 550.1513 of the Michigan Compiled Laws, are amended and sections 402b, 402c, 403b, 403c, 403d, 403e, 405a, 405b, 407a, 407b, 407c, 407d, and 408a are added to read as follows:

Sec. 301. (1) The property and lawful business of a health care corporation existing and authorized to do business under this act shall be held and managed by a board of directors to consist of not more than 35 members SELECTED SO AS TO REPRESENT ALL GEOGRAPHIC AREAS OF THIS STATE IN PROPORTIONS THAT FAIRLY REPRESENT THE TOTAL POPULATION OF THIS STATE. The board shall exercise the powers and authority necessary to carry out the lawful purposes of the corporation, as limited by this act and the articles of incorporation and the bylaws of the corporation.

(2) Four voting members of the board shall be representatives of the public AND 2 VOTING MEMBERS OF THE BOARD SHALL BE REPRESENTATIVES OF HEALTH CARE CONSUMERS. THE 6 REPRESENTATIVES UNDER THIS SUBSECTION SHALL BE appointed by the governor by and with the advice and consent of the senate. Two of ~~those~~ THE 4 PUBLIC members shall be retired individuals 62 years of age or older. The term of office of each representative ~~of the public~~ UNDER THIS SUBSECTION shall be 2 years, and until a successor is appointed and qualified. If a vacancy occurs before the conclusion of a 2-year term, the appointment of a representative to complete the term shall be made in the same manner as the original appointment.

(3) The board of directors shall consist of ~~not more than 25%~~ 33% provider directors. In addition to physician and

hospital provider directors, not less than 1 provider director shall be a registered professional nurse who shall be representative of licensees under part 172 of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws, and not less than 1 provider director shall be representative of the provider whose services, in the 1984 calendar year in the case of an existing health care corporation, or, in the calendar year immediately following incorporation in the case of a newly-formed health care corporation, generated the largest number of benefit claims received by the corporation from its subscribers. Other provider directors shall be as broadly representative of provider classes as possible.

(4) The bylaws of a health care corporation may authorize not more than 1 officer or employee of the corporation to serve as a voting or nonvoting director.

(5) The remaining members of the board of directors shall include ~~representatives~~ THE FOLLOWING:

(A) REPRESENTATIVES of large subscriber groups, medium subscriber groups, small subscriber groups, and nongroup subscribers, in proportions which fairly represent the total subscriber population of the health care corporation. However, at least 3 directors shall represent nongroup subscribers, at least 1 of whom shall be a retired individual 62 years of age or older, and at least 3 directors shall represent small subscriber groups. Large and medium subscriber groups shall be represented, to the greatest extent possible, by an equal number of labor and

management representatives and shall be categorized as labor subscriber representatives or management subscriber representatives.

(B) ONE REPRESENTATIVE FROM THE NATIONAL FEDERATION OF INDEPENDENT BUSINESSES, MICHIGAN CHAPTER.

(C) ONE REPRESENTATIVE FROM THE SMALL BUSINESS ASSOCIATION OF MICHIGAN.

(6) The method of selection of the directors, other than the directors who are representatives of the public, and additional provisions and requirements for further refinement or specification regarding the number of directors comprising each component shall be specified in the bylaws. The terms of office of directors, other than the directors who are representatives of the public, and the method for filling vacancies in those offices shall be provided in the bylaws. However, if a term of office of more than 1 year is prescribed by the bylaws, at least 1/3 of the members of the board shall be selected each year.

(7) The method of selection of each category of subscribers entitled to representation on the board under subsection (5) shall maximize subscriber participation to the extent reasonably practicable. This subsection shall permit, but not require, the statewide election of a director or member of the corporate body. The method of selection shall neither permit nor require nomination, endorsement, approval, or confirmation of a candidate or director by the corporate body, the board of directors, or the management of the health care corporation, or any member or members of any of these. This subsection shall not apply to the

selection of an officer or employee as a director pursuant to subsection (4). This subsection shall not limit the rights of any director, member of the corporate body, or employee or officer of the health care corporation to participate in the selection process in his or her capacity as a subscriber, to the same extent as any other subscriber may participate.

(8) For the purposes of this section:

(a) "Health care provider" or "provider" includes:

(*i*) A person defined as a health care provider or provider in section 105(4); a person employed by a health care facility, as defined in section 105(3); or a director, officer, or trustee of a health care provider, as defined in section 105(4), unless the person serves in that capacity as a representative selected by the same subscriber group or collective bargaining representative which the person represents on the board of a health care corporation.

(*ii*) Except as provided in subdivision (b), a spouse, child, or parent of a health care provider who resides in the same household.

(*iii*) A person who receives more than 25% of his or her annual income through the provision of goods or services to health care providers, or who is an employee, officer, trustee, or director of a firm or organization which receives more than 25% of its annual income through the provision of goods or services to health care providers.

(b) For purposes of determining whether a director is a provider director, "health care provider" or "provider" does not

include a spouse, child, or parent of a health care provider who resides in the same household if all of the following criteria are met:

(*i*) Not more than 1/3 of the total annual household income is earned by that health care provider.

(*ii*) The term of office of the director commences in the 1988 calendar year.

(*iii*) Not more than 2 directors qualify for the exemption under this subdivision.

(9) A director shall not be an employee, agent, officer, or director of an insurance company writing disability insurance inside or outside this state.

SEC. 402B. (1) THE REVIEW BOARD IS CREATED WITHIN THE INSURANCE BUREAU.

(2) THE REVIEW BOARD SHALL CONSIST OF THE FOLLOWING MEMBERS:

(A) TWO REPRESENTATIVES OF THE HEALTH CARE CORPORATION SELECTED BY THE HEALTH CARE CORPORATION.

(B) FOUR PROVIDER REPRESENTATIVES APPOINTED BY THE COMMISSIONER.

(C) THE COMMISSIONER OR HIS OR HER DESIGNATED REPRESENTATIVE.

(3) THE MEMBERS FIRST APPOINTED TO OR SELECTED FOR THE REVIEW BOARD SHALL BE APPOINTED OR SELECTED WITHIN 14 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION.

(4) REVIEW BOARD MEMBERS APPOINTED BY THE COMMISSIONER SHALL SERVE FOR TERMS OF 3 YEARS, OR UNTIL A SUCCESSOR IS APPOINTED,

WHICHEVER IS LATER, EXCEPT THAT OF THE MEMBERS FIRST APPOINTED, 2 SHALL SERVE FOR 1 YEAR, 2 SHALL SERVE FOR 2 YEARS, AND 3 SHALL SERVE FOR 3 YEARS.

(5) IF A VACANCY OCCURS ON THE REVIEW BOARD, THE COMMISSIONER SHALL MAKE AN APPOINTMENT FOR THE UNEXPIRED TERM IN THE SAME MANNER AS THE ORIGINAL APPOINTMENT.

(6) THE COMMISSIONER MAY REMOVE A REVIEW BOARD MEMBER ONLY FOR GOOD CAUSE.

(7) THE REVIEW BOARD'S FIRST MEETING SHALL BE CALLED WITHIN 30 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION. AT THE FIRST MEETING, THE REVIEW BOARD SHALL ELECT FROM AMONG ITS MEMBERS A CHAIRPERSON AND OTHER OFFICERS AS IT CONSIDERS NECESSARY OR APPROPRIATE. AFTER THE FIRST MEETING, THE REVIEW BOARD SHALL MEET AT LEAST QUARTERLY OR MORE FREQUENTLY AT THE CALL OF THE CHAIRPERSON.

(8) A MAJORITY OF THE REVIEW BOARD'S MEMBERS CONSTITUTES A QUORUM FOR THE TRANSACTION OF BUSINESS AT A REVIEW BOARD MEETING. A MAJORITY OF THE MEMBERS PRESENT AND SERVING IS REQUIRED FOR OFFICIAL ACTION OF THE REVIEW BOARD.

(9) THE BUSINESS WHICH THE REVIEW BOARD MAY PERFORM SHALL BE CONDUCTED AT A PUBLIC MEETING HELD IN COMPLIANCE WITH THE OPEN MEETINGS ACT, ACT NO. 267 OF THE PUBLIC ACTS OF 1976, BEING SECTIONS 15.261 TO 15.275 OF THE MICHIGAN COMPILED LAWS.

(10) A WRITING PREPARED, OWNED, USED, IN POSSESSION OF, OR RETAINED BY THE REVIEW BOARD IN PERFORMANCE OF AN OFFICIAL FUNCTION IS SUBJECT TO THE FREEDOM OF INFORMATION ACT, ACT NO. 442 OF

THE PUBLIC ACTS OF 1976, BEING SECTIONS 15.231 TO 15.246 OF THE MICHIGAN COMPILED LAWS.

(11) REVIEW BOARD MEMBERS SHALL SERVE WITHOUT COMPENSATION. HOWEVER, REVIEW BOARD MEMBERS MAY BE REIMBURSED FOR THEIR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR OFFICIAL DUTIES AS REVIEW BOARD MEMBERS.

(12) THE REVIEW BOARD SHALL DO ALL OF THE FOLLOWING:

(A) REVIEW AND MAKE RECOMMENDATIONS CONCERNING PREAUTHORIZATION PROCEDURES.

(B) EXAMINE AND MAKE RECOMMENDATIONS CONCERNING TIMELINESS OF RESPONSES TO PREAUTHORIZATION REQUESTS.

(C) EXAMINE AND MAKE RECOMMENDATIONS CONCERNING A DEFINITION OF MEDICAL NECESSITY FOR PAYMENT PURPOSES.

(D) PREPARE ANNUALLY AND DISTRIBUTE TO THE HEALTH CARE CORPORATION AND THE SENATE AND HOUSE OF REPRESENTATIVES' STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES A REPORT ON SUBDIVISIONS (A) THROUGH (C).

SEC. 402C. A PREAUTHORIZATION REQUEST SHALL BE GIVEN TIMELY AND SHALL CONSIDER EXTENUATING CIRCUMSTANCES INCLUDING, BUT NOT LIMITED TO, AGE, TRAVEL NEEDS, AND WEATHER CONDITIONS.

SEC. 403B. NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, FOR THE SAME HEALTH CARE SERVICE BY THE SAME CLASS OF PROVIDERS, A HEALTH CARE CORPORATION SHALL REIMBURSE A SUBSCRIBER OR PARTICIPATING OR NONPARTICIPATING HEALTH CARE PROVIDER AT THE SAME RATE REGARDLESS OF GEOGRAPHIC LOCATION.

SEC. 403C. (1) A HEALTH CARE CORPORATION SHALL NOT DENY PAYMENT, CONTINUED CARE, OR OTHER BENEFITS IN WHOLE OR IN PART TO

A SUBSCRIBER OR PARTICIPATING OR NONPARTICIPATING HEALTH CARE PROVIDER FOR COVERED HEALTH CARE SERVICES RENDERED UNLESS A REVIEW OF THE REQUEST FOR REIMBURSEMENT, CONTINUED CARE, OR OTHER BENEFITS HAS BEEN CONDUCTED BY A STATE LICENSED AND PRACTICING MEMBER OF THE SAME PROFESSION AS THE PROVIDER THAT RENDERED OR PRESCRIBED THE SERVICE OR IF THE PROVIDER THAT RENDERED OR PRESCRIBED THE SERVICE IS BOARD CERTIFIED, THEN BY A STATE LICENSED AND PRACTICING MEMBER OF THE SAME PROFESSION WHO IS ALSO BOARD CERTIFIED IN THE SAME AREA AS THE PROVIDER THAT RENDERED OR PRESCRIBED THE SERVICE. IF DENIAL OF PAYMENT, CONTINUED CARE, OR OTHER BENEFITS IN WHOLE OR IN PART IS RECOMMENDED, A DETAILED EXPLANATION AS TO THE GROUNDS FOR THE DENIAL SHALL BE SENT TO BOTH THE SUBSCRIBER AND THE HEALTH CARE PROVIDER WITHIN 30 DAYS OF THE REQUEST FOR PAYMENT, CONTINUED CARE, OR OTHER BENEFITS. AS USED IN THIS SUBSECTION, "PRACTICING" MEANS EARNING 75% OF ANNUAL INCOME FROM ACTIVE PATIENT CARE IN THIS STATE.

(2) A HEALTH CARE CORPORATION SHALL NOT COMPENSATE ANY PERSON WHO REVIEWS FOR THE CORPORATION A REQUEST FOR REIMBURSEMENT, CONTINUED CARE, OR OTHER BENEFITS BASED UPON THE RESULT RECOMMENDED BY THAT PERSON OR THE COST OF THE CLAIM.

(3) THIS SECTION SHALL NOT APPLY IF DENIAL OF PAYMENT, CONTINUED CARE, OR OTHER BENEFITS IS BASED UPON FAILURE TO PAY THE CERTIFICATE PREMIUM OR FOLLOW THE CERTIFICATE'S PROCEDURES FOR REQUESTING PAYMENT, CONTINUED CARE, OR OTHER BENEFITS.

SEC. 403D. UPON REQUEST, A HEALTH CARE CORPORATION SHALL MAIL TO A SUBSCRIBER A WRITTEN EXPLANATION OF HIS OR HER BENEFITS INCLUDING THE COST OF ANY GIVEN PROCEDURE, ANY CO-PAYMENT

REQUIREMENTS, BENEFIT PLAN LIMITATIONS, AND ELIGIBILITY REQUIREMENTS.

SEC. 403E. EACH HEALTH CARE CORPORATION SHALL DISCLOSE LIMITATIONS AND ELIGIBILITY REQUIREMENTS OF A BENEFIT PLAN IN ALL ADVERTISING AND MARKETING MATERIALS FOR THAT PLAN.

SEC. 405A. EACH HEALTH CARE CORPORATION SHALL ESTABLISH AND MAINTAIN A LIAISON COMMITTEE WITH PROVIDERS ON CLAIM FORM DEVELOPMENT AND USE. THE LIAISON COMMITTEE SHALL PROVIDE INFORMATION ON PROPER SUBMISSION OF CLAIMS DIRECTLY TO PROVIDERS AND FOR DISTRIBUTION THROUGH THE MEETINGS HELD PURSUANT TO SECTION 405B.

SEC. 405B. THE SENIOR MANAGEMENT OF A HEALTH CARE CORPORATION SHALL HOLD NOT LESS THAN 6 MEETINGS WITH PROVIDERS ANNUALLY. THE MEETINGS SHALL BE HELD IN AREAS AROUND THE STATE WITH THE THE AREAS SELECTED SO AS TO FOSTER THE ATTENDANCE OF ALL PROVIDERS IN THE STATE. NOT LESS THAN 1 MONTH PRIOR TO EACH MEETING, THE HEALTH CARE CORPORATION SHALL NOTIFY PROVIDERS IN THE AREA OF THE TIME, DATE, AND LOCATION OF THE MEETING. EACH MEETING SHALL BE DESIGNED TO IMPROVE COMMUNICATION AND RELATIONS BETWEEN THE HEALTH CARE CORPORATION AND PROVIDERS AND SHALL INCLUDE INFORMATION ON CLAIM FORMS, PREAUTHORIZATION PROCEDURES, DEFINITION OF MEDICAL NECESSITY, AND OTHER PROCEDURES.

Sec. 407. (1) A health care corporation shall establish and maintain a complaint system ~~which~~ THAT affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by members concerning any matter relating to the provisions of a certificate. At a minimum, procedures shall be developed by a corporation for the resolution of claims for

reimbursement; denial, cancellations, or nonrenewals of certificates; and complaints regarding the quality of the services delivered by health care providers and health care facilities ~~which~~ THAT receive reimbursement from the corporation.

(2) A health care corporation, within 30 days after receipt of written complaint, shall give a reasonable written response to each written complaint ~~which~~ THAT it receives. The commissioner shall have free access, as defined in section 603(2), to complaints and responses, which shall be made available to the commissioner for inspection. If the matter complained of is reasonably believed by the complainant to be a violation of section 402 or 403, the complainant shall be entitled to a private informal managerial-level conference with the health care corporation, as provided for in section 404.

(3) The health care corporation shall maintain a complete record of all of the written complaints of its members ~~which~~ THAT the corporation has received since the date of the last examination. This record shall indicate the total number of complaints; and by line of business, the nature of each complaint, the disposition of each complaint, and the time taken to process each complaint.

(4) A health care corporation shall submit to THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES AND TO the commissioner an annual report ~~which~~ THAT describes the complaint system of the corporation, and includes a compilation and analysis of the written complaints filed with the corporation, their disposition and underlying causes, and

measures being implemented to alleviate those causes. The report shall be compiled in a manner ~~which~~ THAT protects an individual's right to privacy with respect to medical information and shall not disclose the identity of a member by name or other personal identifier without the member's consent pursuant to section 406(1). The annual report shall be a public record.

(5) This section shall not prevent a member from seeking other remedies available by law.

SEC. 407A. (1) WITHIN 1 MONTH AFTER THE EFFECTIVE DATE OF THIS SECTION, THE COMMISSIONER SHALL AUDIT, AT THE HEALTH CARE CORPORATION'S EXPENSE, THE HEALTH CARE CORPORATION'S INQUIRY AND COMPLAINT DEPARTMENT TO DETERMINE ALL OF THE FOLLOWING:

(A) THE HEALTH CARE CORPORATION'S BLOCKED CALL RATE.

(B) THE ACCURACY AND PROMPTNESS OF THE RESPONSES GIVEN TO QUESTIONS ASKED OF THE HEALTH CARE CORPORATION.

(C) WHETHER HEALTH CARE CORPORATION EMPLOYEES IDENTIFY THEMSELVES TO CALLERS.

(2) THE COMMISSIONER SHALL PREPARE A REPORT ON THE COMMISSIONER'S FINDINGS UNDER SUBSECTION (1) WITHIN 30 DAYS AFTER THE COMPLETION OF THE AUDIT AND SHALL DISTRIBUTE THE REPORT TO THE HEALTH CARE CORPORATION AND TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES.

(3) IF THE REPORT PREPARED PURSUANT TO SUBSECTION (2) SHOWS THAT BLOCKED CALLS EXCEED 10%, THAT QUESTIONS ARE NOT ANSWERED ACCURATELY OR PROMPTLY, OR THAT HEALTH CARE CORPORATION EMPLOYEES DO NOT IDENTIFY THEMSELVES TO CALLERS, THE HEALTH CARE CORPORATION SHALL CONDUCT MONTHLY INTERNAL AUDITS OF THEIR

INQUIRY AND COMPLAINT DEPARTMENT FOR 1 YEAR. THE MONTHLY AUDITS SHALL EXAMINE THE FACTORS LISTED IN SUBSECTION (1)(A) TO (C). THE HEALTH CARE CORPORATION SHALL PREPARE A REPORT ON THE HEALTH CARE CORPORATION'S FINDINGS UNDER THIS SUBSECTION AND RECOMMENDATIONS ON MEANS TO IMPROVE THE FINDINGS WITHIN 30 DAYS AFTER THE COMPLETION OF EACH AUDIT AND SHALL DISTRIBUTE THE REPORT TO THE COMMISSIONER AND TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES.

(4) IF THE HEALTH CARE CORPORATION PREPARES MONTHLY AUDITS UNDER SUBSECTION (3), THE COMMISSIONER SHALL DO A FOLLOW-UP AUDIT, AT THE HEALTH CARE CORPORATION'S EXPENSE, OF THE HEALTH CARE CORPORATION'S INQUIRY AND COMPLAINT DEPARTMENT. THE FOLLOW-UP AUDIT SHALL BE CONDUCTED 13 MONTHS AFTER THE FIRST MONTHLY AUDIT CONDUCTED UNDER SUBSECTION (3). THE FOLLOW-UP AUDIT SHALL EXAMINE THE FACTORS LISTED IN SUBSECTION (1)(A) TO (C).

(5) THE COMMISSIONER SHALL PREPARE A REPORT ON THE COMMISSIONER'S FINDINGS UNDER SUBSECTION (4), SHALL COMPARE THE FINDINGS TO THE THE FINDINGS IN THE REPORT PREPARED UNDER SUBSECTION (2), SHALL MAKE RECOMMENDATIONS ON MEANS TO IMPROVE THE FINDINGS WITHIN 30 DAYS AFTER THE COMPLETION OF THE AUDIT, AND SHALL DISTRIBUTE THE REPORT TO THE HEALTH CARE CORPORATION AND TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES.

SEC. 407B. (1) THE COMMISSIONER SHALL ESTABLISH AND MAINTAIN APPEALS BOARDS TO PROVIDE FOR THE EXPEDITIOUS RESOLUTION OF WRITTEN COMPLAINTS INITIATED BY MEMBERS OR HEALTH CARE

PROVIDERS. A MEMBER OR PROVIDER SHALL HAVE THE RIGHT TO APPEAL TO THE APPEALS BOARD ONLY IF ALL APPEALS WITHIN THE HEALTH CARE CORPORATION'S SYSTEM HAVE BEEN EXHAUSTED.

(2) EACH APPEALS BOARD SHALL CONSIST OF 1 REPRESENTATIVE FROM THE HEALTH CARE CORPORATION AND 2 REPRESENTATIVES APPOINTED BY THE COMMISSIONER AS FOLLOWS:

(A) ONE REPRESENTATIVE OF HEALTH CARE PROVIDERS. IF THE APPEAL IS BROUGHT BY A HEALTH CARE PROVIDER, THE HEALTH CARE PROVIDER APPEALS BOARD REPRESENTATIVE SHALL BE A STATE LICENSED AND PRACTICING MEMBER OF THE SAME PROFESSION AS THE PROVIDER THAT BROUGHT THE APPEAL OR IF THE PROVIDER THAT BROUGHT THE APPEAL IS BOARD CERTIFIED, SHALL BE A STATE LICENSED AND PRACTICING MEMBER OF THE SAME PROFESSION WHO IS ALSO BOARD CERTIFIED IN THE SAME AREA AS THE PROVIDER THAT BROUGHT THE APPEAL. AS USED IN THIS SUBDIVISION, "PRACTICING" MEANS EARNING 75% OF ANNUAL INCOME FROM ACTIVE PATIENT CARE IN THIS STATE.

(B) ONE REPRESENTATIVE OF THE PUBLIC. THE PUBLIC REPRESENTATIVE SHALL CHAIR MEETINGS OF THE APPEALS BOARD.

(3) THE COMMISSIONER SHALL ESTABLISH THE APPROPRIATE NUMBER OF APPEALS BOARDS UNDER SUBSECTION (1) AS THE COMMISSIONER CONSIDERS NECESSARY.

(4) THE COMMISSIONER SHALL PROMULGATE RULES PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT TO IMPLEMENT THIS SECTION.

(5) THIS SECTION SHALL NOT PREVENT A MEMBER OR HEALTH CARE PROVIDER FROM SEEKING OTHER REMEDIES AVAILABLE BY LAW.

SEC. 407C. IF A COMPLAINT IS SETTLED OR RESOLVED FOR A MEMBER OR HEALTH CARE PROVIDER BY A HEALTH CARE CORPORATION OR BY

THE APPEALS BOARD UNDER SECTION 407B, THE HEALTH CARE CORPORATION SHALL SUBSEQUENTLY PROVIDE THE SAME SETTLEMENT OR RESOLUTION FOR MEMBERS OR HEALTH CARE PROVIDERS WITH THE SAME SITUATION AND, SUBJECT TO SECTION 406, SHALL NOTIFY MEMBERS AND HEALTH CARE PROVIDERS OF THE POLICY ESTABLISHED.

SEC. 407D. THE COMMISSIONER SHALL AUDIT ANNUALLY THE OPERATION OF A HEALTH CARE CORPORATION TO DETERMINE IF THE HEALTH CARE CORPORATION IS COMPLYING WITH SECTIONS 402C, 403B, 403C, 403D, 403E, 405A, 405B, AND 407C. IF THE COMMISSIONER FINDS AFTER A HEARING HELD IN COMPLIANCE WITH THE ADMINISTRATIVE PROCEDURES ACT THAT THE HEALTH CARE CORPORATION IS NOT COMPLYING WITH SECTIONS 402C, 403B, 403C, 403D, 403E, 405A, 405B, OR 407C, THE COMMISSIONER MAY IMPOSE UPON THE HEALTH CARE CORPORATION A CIVIL FINE OF NOT MORE THAN $5,000.00 FOR EACH VIOLATION.

SEC. 408A. (1) THE FRAUD REVIEW PANEL IS CREATED.

(2) THE FRAUD REVIEW PANEL SHALL CONSIST OF THE FOLLOWING MEMBERS:

(A) ONE REPRESENTATIVE OF THE HEALTH CARE CORPORATION.

(B) ONE REPRESENTATIVE FROM THE DEPARTMENT OF SOCIAL SERVICES.

(C) ONE REPRESENTATIVE FROM THE BUREAU OF HEALTH.

(D) ONE REPRESENTATIVE FROM THE DEPARTMENT OF STATE POLICE.

(E) TWO PROVIDER REPRESENTATIVES APPOINTED BY THE COMMISSIONER.

(F) THE COMMISSIONER OR HIS OR HER DESIGNATED REPRESENTATIVE.

(3) THE MEMBERS FIRST APPOINTED TO OR SELECTED FOR THE FRAUD REVIEW PANEL SHALL BE APPOINTED OR SELECTED WITHIN 14 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION.

(4) THE FRAUD REVIEW PANEL'S FIRST MEETING SHALL BE CALLED WITHIN 30 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION. AT THE FIRST MEETING, THE FRAUD REVIEW PANEL SHALL ELECT FROM AMONG ITS MEMBERS A CHAIRPERSON AND OTHER OFFICERS AS IT CONSIDERS NECESSARY OR APPROPRIATE.

(5) A MAJORITY OF THE FRAUD REVIEW PANEL'S MEMBERS CONSTITUTES A QUORUM FOR THE TRANSACTION OF BUSINESS AT A FRAUD REVIEW PANEL MEETING. A MAJORITY OF THE MEMBERS PRESENT AND SERVING IS REQUIRED FOR OFFICIAL ACTION OF THE FRAUD REVIEW PANEL.

(6) THE BUSINESS WHICH THE FRAUD REVIEW PANEL MAY PERFORM SHALL BE CONDUCTED AT A PUBLIC MEETING HELD IN COMPLIANCE WITH THE OPEN MEETINGS ACT, ACT NO. 267 OF THE PUBLIC ACTS OF 1976, BEING SECTIONS 15.261 TO 15.275 OF THE MICHIGAN COMPILED LAWS.

(7) A WRITING PREPARED, OWNED, USED, IN POSSESSION OF, OR RETAINED BY THE FRAUD REVIEW PANEL IN PERFORMANCE OF AN OFFICIAL FUNCTION IS SUBJECT TO THE FREEDOM OF INFORMATION ACT, ACT NO. 442 OF THE PUBLIC ACTS OF 1976, BEING SECTIONS 15.231 TO 15.246 OF THE MICHIGAN COMPILED LAWS.

(8) FRAUD REVIEW PANEL MEMBERS SHALL SERVE WITHOUT COMPENSATION. HOWEVER, FRAUD REVIEW PANEL MEMBERS MAY BE REIMBURSED FOR THEIR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR OFFICIAL DUTIES AS FRAUD REVIEW PANEL MEMBERS.

(9) THE FRAUD REVIEW PANEL SHALL EXAMINE THE HEALTH CARE CORPORATION'S CURRENT FRAUD PREVENTION AND DETECTION SYSTEM AND SHALL MAKE RECOMMENDATIONS ON WHAT ARE AND WHAT ARE NOT EFFECTIVE FRAUD PREVENTION AND DETECTION SYSTEMS, INCLUDING, BUT NOT LIMITED TO, THE USE OF PROFILES AND STATISTICAL MODELS, SURVEILLANCE, AND DRUG UTILIZATION. THE FRAUD REVIEW PANEL SHALL PREPARE AND DISTRIBUTE TO THE HEALTH CARE CORPORATION AND THE SENATE AND HOUSE OF REPRESENTATIVES' STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES A REPORT ON THE FRAUD REVIEW PANEL'S FINDINGS AND RECOMMENDATIONS BY NOT LATER THAN 1 YEAR AFTER THE EFFECTIVE DATE OF THIS SECTION.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services ~~which~~ THAT the professional health care providers may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies to the health care corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

~~(b) That the provider will accept payment from the corporation as payment in full for all cases involving the procedure specified, for the duration of the calendar year. Until January 1, 1993, as used in this subdivision, provider does not~~

~~include a person licensed as a dentist under part 166 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16601 to 333.16648 of the Michigan Compiled Laws.~~

(B) ~~(c)~~ That the provider will not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age, handicap, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into pursuant to subsection (1) shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which it has contracted prior to August 27, 1985 and ~~which~~ THAT continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection shall not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, nor to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services ~~which~~ THAT are overutilized, including those

services rendered, ordered, or prescribed to an extent ~~which is~~ greater than reasonably necessary.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation ~~, which~~ THAT can be publicly displayed ~~,~~ to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section shall not be construed to impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section shall be subject to the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding medical or surgical outpatient facility on the

basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities.

~~, is~~ NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A HEALTH CARE CORPORATION SHALL NOT DENY PARTICIPATION TO A FREESTANDING MEDICAL OR SURGICAL OUTPATIENT FACILITY ON THE BASIS THAT THE FACILITY IS NOT licensed under part 208 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20801 to 333.20821 of the Michigan Compiled Laws, ~~and complies~~ OR DOES NOT COMPLY with part ~~221~~ 222 of the public health code, Act No. 368 of the Public Acts of 1978, as amended, being sections ~~333.22101 to 333.22181~~ 333.22201 TO 333.22260 of the Michigan Compiled Laws, IF THE DEPARTMENT OF PUBLIC HEALTH OTHERWISE PERMITS THE OPERATION OF THE FACILITY.

Sec. 506. (1) A health care corporation shall transmit a copy of each provider class plan to the SENATE AND HOUSE OF REPRESENTATIVES' STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES FOR REVIEW AND COMMENT AND TO THE commissioner 45 days before the earliest effective date of a provider contract or reimbursement arrangement for the appropriate provider class. The initial provider class plan for each class, which shall include provider contracts and reimbursement arrangements under which the corporation and a provider class are operating on the effective date of this act, shall be transmitted to the commissioner within 45 days after the effective date of this act, except where a provider class plan reimburses on a prospective basis, in which case the plan shall be transmitted within 1 year and 45 days after the effective date of this act.

(2) Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract. For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan.

(3) If the commissioner determines that the plan does not contain a reimbursement arrangement, objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, contract provisions, the commissioner, within 15 days after receipt of the plan, shall notify the corporation by certified or registered mail, along with a written statement of the items omitted, AND SHALL SEND A COPY TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES.

(4) If the commissioner does not notify the health care corporation pursuant to subsection (3), the provider class plan shall be automatically placed into effect, and shall be retained for the commissioner's records. Provider class plans approved by the commissioner or an independent hearing officer under this part shall be considered retained for the commissioner's records under this subsection.

Sec. 508. (1) Except during the 6-month period provided in section 509(2), a provider class plan retained by the commissioner as provided in section 506(4) may be modified by the

health care corporation after the retention, under either of the following circumstances:

(a) If the plan was prepared by the health care corporation and is not a plan prepared pursuant to section 511(1) or 515(4). However, the modification shall not take effect until after the modification has been filed with the commissioner AND SUBMITTED TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE MATTERS.

(b) In all other cases, if the modification has been filed with and is agreed to by the commissioner.

(2) A modification made under subsection (1) shall not extend the time periods provided in section 509(1). In developing plan modifications, a health care corporation shall obtain advice and consultation from providers in the relevant provider class and from subscribers pursuant to section 505. Before agreeing to plan modifications under subsection (1)(b), the commissioner shall obtain advice and consultation FROM THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES AND pursuant to section 505(2).

Sec. 509. (1) The commissioner may determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan, at the following times:

(a) For a provider contract or a reimbursement arrangement that was in effect prior to the effective date of this act, upon the expiration of 2 years after the filing date under section 506.

(b) For a provider class plan retained by the commissioner as provided in section 506(4), upon the expiration of 2 years after the earliest effective date of the provider contract or a reimbursement arrangement for the appropriate provider class.

(c) For a class plan retained by the commissioner as provided in section 506(4) that has not been subject to a determination under this section within the time period provided in subsection (2), within 2 years after the expiration of that time period.

(2) Before making a determination under subsection (1), and not later than 30 days following expiration of the appropriate 2-year time period described in subsection (1)(a), (b), or (c), the commissioner shall give written notice to the health care corporation, TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES, and to each person who has requested a copy of such notice, that he or she intends to make a determination with respect to a particular provider class plan. The commissioner shall have 6 months to reach a determination under subsection (1).

(3) A modification made pursuant to section 508(1) shall not be taken into consideration for purposes of computing the time periods described in subsections (1) and (2).

(4) The commissioner shall consider all of the following in making a determination pursuant to subsection (1):

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The

commissioner shall give weight to each of the goals provided in section 504, shall not focus on 1 goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers.

(c) Information submitted or obtained for the record concerning: demographic trends; epidemiological trends; and long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d); sudden changes in circumstances; administrative agency or judicial actions; changes in health care practices and technology; and changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.

(d) Health care legislation of this state or of the federal government. As used in this subdivision, "health care legislation" does not include THE INSURANCE CODE OF 1956, Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, COMMENTS RECEIVED BY THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES, and comments received pursuant to section 505(2).

(5) In making a determination pursuant to subsection (1), the commissioner shall provide a detailed statement of findings

which support that determination, including a consideration of the information and factors described in subsection (4).

(6) All data, analyses, and factors, quantified or otherwise, at a minimum, shall include the 2-year period being evaluated.

(7) The commissioner shall make a sufficient number of determinations regarding provider class plans under this section, so that during each 3-year period following the effective date of this act, there is a review of provider class plans which, taken together, account for at least 75% of the total corporation payout to providers for the 3-year period.

(8) Determinations by the commissioner shall not be contested case hearings under chapter 4 of the administrative procedures act. This subsection shall not be construed to apply with respect to appeals under section 515.

Sec. 510. (1) After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in section 504, and the objectives contained in the provider class plan, the commissioner shall ~~determined~~ DETERMINE 1 of the following:

(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

(b) That although the provider class plan does not substantially achieve 1 or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure

to achieve 1 or more of the goals was reasonable due to factors listed in section 509(4).

(c) That a provider class plan does not substantially achieve 1 or more of the goals of the corporation as provided in section 504.

(2) The commissioner shall notify the health care corporation, THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES, and each person who has requested a copy of such notice, of a determination under subsection (1) by certified or registered mail. Determinations made pursuant to subsection (1)(b) or (c) shall include a concise written statement of specific findings supporting that determination.

(3) An existing provider contract or reimbursement arrangement shall remain in effect until a new provider class plan has been retained and placed into effect as provided in section 506(4). A provider class plan shall not be subject to further review until the expiration of the time period provided in section 509(1).

(4) A provider class plan with respect to which a determination was made under subsection (1)(a) or (b) shall not be subject to further review until the expiration of 2 years following the determination.

Sec. 511. (1) Upon receipt of notice under section 510(2), the health care corporation, within 6 months or a period determined by the commissioner pursuant to section 512, shall transmit to the commissioner AND TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE

ISSUES a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES AND FROM providers in the provider class and subscribers, using procedures established pursuant to section 505.

(2) If, after the expiration of 6 months or a period determined by the commissioner pursuant to section 512, the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan pursuant to section 513(2)(a), for that provider class.

Sec. 513. (1) Upon receipt of a provider class plan under section 511(1), the commissioner, after considering the information and factors described in section 509(4), within 90 days shall examine the plan and determine if the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner. If the commissioner determines that the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner, the plan shall be automatically retained and placed into effect as provided in section 506.

(2) If the commissioner determines that the plan does not substantially achieve the goals, does not achieve the objectives,

and does not substantially overcome the deficiencies enumerated in the findings made by the commissioner pursuant to section 510(2), the commissioner shall do all of the following:

(a) Prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made pursuant to section 510(2), and transmit that plan to the health care corporation. A provider class plan prepared pursuant to this subdivision shall be retained for the commissioner's records and placed into effect as provided in section 506(4), unless a request for an appeal is made under subdivision (b).

(b) Give written notice to the health care corporation of an opportunity for an appeal pursuant to section 515. The notice shall state that a request for an appeal shall be made by the corporation within 30 days after the receipt of notice under this subdivision.

(3) In making a determination pursuant to subsection (1), or preparing a plan pursuant to subsection (2)(a), the commissioner shall obtain advice and consultation **FROM THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES AND** pursuant to section 505(2). The commissioner shall also forward a copy of each notice issued under subsection (2)(b) to each person requesting a copy. The copy shall notify the person of an opportunity for an appeal pursuant to section 515, and that a request for such an appeal is required to be made within 30 days after the receipt of notice given under this subsection.