HOUSE BILL No. 5769

April 28, 1992, Introduced by Reps. Berman, Van Singel, Jondahl, Pitoniak, Barns, DeMars and Scott and referred to the Committee on Insurance.

A bill to amend section 402 of Act No. 350 of the Public Acts of 1980, entitled as amended "The nonprofit health care corporation reform act," as amended by Act No. 132 of the Public Acts of 1989, being section 550.1402 of the Michigan Compiled Laws; and to add sections 402a, 416b, and 501b.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Section 402 of Act No. 350 of the Public Acts of 1980, as amended by Act No. 132 of the Public Acts of 1989, being section 550.1402 of the Michigan Compiled Laws, is amended and sections 402a, 416b, and 501b are added to read as follows:

Sec. 402. (1) A health care corporation shall not do any of the following:

(a) Misrepresent pertinent facts or certificate provisions relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within ~~a reasonable time~~ 30 DAYS after a claim has been received.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

(g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.

(h) By making reference to written or printed advertising material accompanying or made part of an application for coverage, attempt to settle a claim for less than the amount which a reasonable person would believe was due under the certificate.

(i) For the purpose of compelling a member to accept a settlement or compromise in a claim, make known to the member a policy of appealing from administrative hearing decisions in favor of members.

(j) Attempt to settle a claim on the basis of an application which was altered without notice to, or knowledge or consent of, the subscriber under whose certificate the claim is being made.

(k) Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(~~l~~) Fail to ~~promptly~~ provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement WITHIN 30 DAYS AFTER RECEIPT OF A CLAIM.

(m) Fail to ~~promptly~~ IMMEDIATELY settle a claim ~~where liability has become reasonably clear~~ FOR WHICH THE HEALTH CARE CORPORATION'S LIABILITY under 1 portion of a certificate IS REASONABLY CLEAR in order to influence a settlement under another portion of the certificate.

(2) ~~In order to~~ TO induce a person to contract or to continue to contract with the health care corporation for the provision of health care benefits or administrative or other services offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate issued by the health care corporation; or to induce a person to secure or terminate coverage with another health care corporation, insurer, health maintenance organization, or other person, a health care corporation shall not, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or part of the premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, ~~any~~ AN estimate, illustration, circular, or statement misrepresenting the terms OR BENEFITS of a certificate or contract for administrative or other services, ~~the benefits thereunder,~~ or the true nature ~~thereof~~ OF THAT CERTIFICATE OR CONTRACT.

(e) Make ~~a~~ AN ORAL OR WRITTEN misrepresentation or incomplete comparison ~~, whether oral or written,~~ between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization, or other person.

(3) A health care corporation shall not provide a commission or other compensation to the health care corporation's agent or employee for the sale or service of a health care benefits certificate issued to an individual eligible for medicare, unless the amount of the commission or compensation paid in the first year of the certificate is not more than the amount of the commission or compensation that the health care corporation's agent or employee receives for the certificate in each of the 2 subsequent, consecutive annual renewal periods.

(4) A health care corporation shall not issue a certificate to an individual eligible for medicare that provides for a new

preexisting condition limitation waiting period if coverage is converted to or replaced by a new or other form of similar coverage with the same health care corporation or any of the health care corporation's affiliates. If the preexisting condition limitation waiting period in the original or replaced certificate has not expired, the replacing certificate may include the remaining term of the preexisting condition limitation waiting period of the replaced certificate. This subsection does not apply to an increase in benefits voluntarily selected by the individual.

(5) Nothing in subsection (2) shall prevent a health care corporation from readjusting the rates charged to a subscriber group which is experience-rated based on the previous claims of the group.

(6) The commissioner shall allow a health care corporation to participate in ~~any~~ A trade practice conference for disability insurers convened under section 2047 of THE INSURANCE CODE OF 1956, Act No. 218 of the Public Acts of 1956, being section 500.2047 of the Michigan Compiled Laws, and may bind a health care corporation to any rules promulgated as provided in that section.

(7) Nothing in this section shall alter or supersede any provider class plan established pursuant to part 5.

(8) If the commissioner has probable cause to believe that a health care corporation is ~~violating, or has violated subsection (1), indicating a~~ OR HAS ENGAGED IN CONDUCT PROHIBITED BY THIS SECTION, OR THAT A HEALTH CARE CORPORATION INDICATES A persistent

tendency to engage in conduct prohibited by ~~that~~ subsection (1), ~~or has probable cause to believe that a health care corporation is violating, or has violated subsection (2), (3), or (4),~~ he or she shall ~~give written notice to the corporation, pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the~~ DO EACH OF THE FOLLOWING:

(A) ENSURE THAT THE HEALTH CARE corporation HAS an opportunity to ~~confer and~~ PARTICIPATE IN AN IMMEDIATE INFORMAL CONFERENCE TO discuss ~~the possible complaint and proceedings~~ in person with the commissioner or a representative of the commissioner ~~, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to~~ THE COMPLAINT THAT MAY BE INSTITUTED AGAINST THAT HEALTH CARE CORPORATION AS A RESULT OF THE ALLEGED PROHIBITED CONDUCT.

(B) SUMMARILY RESOLVE ISSUES ADDRESSED AT THE INFORMAL CONFERENCE DESCRIBED IN SUBDIVISION (A) UPON AGREEMENT OF THE PARTIES.

(9) IF A HEALTH CARE CORPORATION FAILS TO PARTICIPATE IN AN INFORMAL CONFERENCE DESCRIBED IN SUBSECTION (8), OR IF AN ISSUE ADDRESSED AT THAT INFORMAL CONFERENCE IS NOT RESOLVED TO THE COMMISSIONER'S SATISFACTION AT THE TIME OF THE CONFERENCE, THE

COMMISSIONER SHALL PROVIDE THE HEALTH CARE CORPORATION WITH A WRITTEN NOTICE OF A HEARING TO BE HELD NO LATER THAN 5 BUSINESS DAYS AFTER THE SCHEDULED DATE OF THE INFORMATION CONFERENCE. THE NOTICE SHALL COMPLY WITH THE ADMINISTRATIVE PROCEDURES ACT OF 1969 AND SHALL IDENTIFY BOTH OF THE FOLLOWING:

(A) THE CONDUCT OF THE HEALTH CARE CORPORATION ALLEGED TO BE PROHIBITED UNDER THIS SECTION.

(B) THE ACTION PROPOSED BY THE COMMISSIONER IN RESPONSE TO THE CONDUCT IDENTIFIED PURSUANT TO SUBDIVISION (A).

(10) SUBSECTIONS (8) AND (9) DO NOT diminish the right of a person to bring an action for damages under this section.

(11) ~~(9)~~ A hearing ~~held pursuant to~~ DESCRIBED IN subsection ~~(8)~~ (9) shall be held in accordance with ~~section 2030~~ EACH OF THE FOLLOWING:

(A) SECTION 2030 OF THE INSURANCE CODE OF 1956, Act No. 218 of the Public Acts of 1956, as amended, being section 500.2030 of the Michigan Compiled Laws. ~~The hearing shall be held pursuant to the~~

(B) THE administrative procedures act of 1969. ~~, Act No. 306 of the Public Acts of 1969.~~

(12) WITHIN 5 BUSINESS DAYS AFTER THE HEARING DESCRIBED IN SUBSECTION (9), THE COMMISSION SHALL ISSUE AND SERVE UPON THE HEALTH CARE CORPORATION AND MAKE AVAILABLE TO THOSE PERSONS WHO APPEARED AT THE HEARING A WRITTEN STATEMENT OF THE COMMISSIONER'S FINDINGS. If ~~, after the hearing,~~ the commissioner determines BY A PREPONDERANCE OF THE EVIDENCE that the health care corporation is ~~violating, or has violated subsection (1),~~

~~indicating a persistent tendency to engage in conduct prohibited by that subsection, or is violating, or has violated subsection (2), (3), or (4), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and~~ OR HAS ENGAGED IN CONDUCT PROHIBITED BY THIS SECTION, OR THAT THE HEALTH CARE CORPORATION INDICATES A PERSISTENT TENDENCY TO ENGAGE IN CONDUCT PROHIBITED BY SUBSECTION (1), THE COMMISSIONER SHALL INCLUDE WITH HIS OR HER WRITTEN STATEMENT OF FINDINGS an order requiring the corporation to cease and desist from engaging in the prohibited activity. The commissioner may ~~at any time, by~~ ISSUE AN order ~~, and after notice and opportunity for a hearing,~~ TO reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, ~~when in his or her opinion conditions~~ IF HE OR SHE DETERMINES THAT THE PUBLIC INTEREST OR A CHANGE of fact or law ~~have so changed as to require~~ REQUIRES that action. ~~, or if the public interest so requires.~~

(13) ~~(10)~~ A health care corporation ~~which~~ THAT violates a cease and desist order of the commissioner issued under subsection ~~(9)~~ (12) OR FAILS TO COMPLY WITH THAT ORDER WITHIN 60 DAYS AFTER BEING SERVED WITH THE ORDER, MAY BE SUBJECT TO A CIVIL FINE OF NOT MORE THAN $10,000.00 FOR EACH VIOLATION, after notice and an opportunity for a hearing, and upon order of the commissioner. ~~, may be subject to a civil fine of not more than $10,000.00 for each violation.~~

(14) ~~(11)~~ In addition to other remedies provided by law, an aggrieved member may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits AND SUBJECT TO SUBSECTION (15), the member shall be awarded actual monetary damages or $200.00, whichever is greater, together with reasonable attorneys' fees.

(15) If the health care corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery ~~shall be~~ IS limited to actual monetary damages.

(16) AS USED IN THIS SECTION, "BUSINESS DAY" MEANS A DAY OF THE YEAR THAT IS NOT A SATURDAY, SUNDAY, OR LEGAL HOLIDAY.

SEC. 402A. BEGINNING 120 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION, A HEALTH CARE CORPORATION SHALL PREPARE AND FILE WITH THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON INSURANCE ISSUES QUARTERLY REPORTS IDENTIFYING THOSE CLAIMS UNDER THIS ACT MADE AGAINST THE HEALTH CARE CORPORATION WITHIN THE 3-MONTH PERIOD IMMEDIATELY PRECEDING THE DATE OF EACH REPORT THAT WERE OR ARE DISPUTED BY THE HEALTH CARE CORPORATION. EACH REPORT SHALL INCLUDE BOTH OF THE FOLLOWING:

(A) THE TOTAL NUMBER OF CLAIMS FILED WITHIN THE 3-MONTH PERIOD THAT WERE OR ARE DISPUTED.

(B) THE RESULTS OF EACH SETTLEMENT OF A DISPUTED CLAIM WITHIN THE 3-MONTH PERIOD, INCLUDING IDENTIFICATION OF THE AMOUNT CLAIMED AND THE AMOUNT PAID.

SEC. 416B. (1) THE ONCOLOGY ADVISORY PANEL IS CREATED WITHIN THE DEPARTMENT OF COMMERCE AND SHALL CONSIST OF 3 MEMBERS APPOINTED BY THE COMMISSIONER WHO ARE EACH OF THE FOLLOWING:

(A) MEMBERS OF THE STATE ONCOLOGY ORGANIZATION.

(B) IDENTIFIED BY THE STATE ONCOLOGY ORGANIZATION AS QUALIFIED TO ADVISE HEALTH CARE CORPORATIONS ABOUT THE EFFICACY AND APPROPRIATENESS OF OFF-LABEL PATIENT TREATMENTS.

(2) THE COMMISSIONER SHALL APPOINT EACH MEMBER WITHIN 90 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION, AND EACH MEMBER SHALL SERVE FOR A TERM OF 5 YEARS, EXCEPT THAT OF THE MEMBERS FIRST APPOINTED, 1 SHALL BE APPOINTED FOR A TERM OF 3 YEARS, 1 SHALL BE APPOINTED FOR A TERM OF 4 YEARS, AND 1 SHALL BE APPOINTED FOR A TERM OF 5 YEARS.

(3) IF A VACANCY OCCURS ON THE ONCOLOGY ADVISORY PANEL, THE COMMISSIONER SHALL MAKE AN APPOINTMENT FOR THE BALANCE OF THE UNEXPIRED TERM IN THE SAME MANNER AS THE ORIGINAL APPOINTMENT.

(4) MEMBERS OF THE ONCOLOGY REVIEW PANEL SHALL SERVE WITHOUT COMPENSATION. HOWEVER, MEMBERS OF THAT PANEL MAY BE REIMBURSED FOR ACTUAL AND NECESSARY EXPENSES THEY MAY HAVE INCURRED IN THE PERFORMANCE OF THEIR OFFICIAL DUTIES AS MEMBERS OF THAT PANEL PURSUANT TO THE STANDARD TRAVEL REGULATIONS OF THE DEPARTMENT OF MANAGEMENT AND BUDGET.

(5) THE ONCOLOGY REVIEW PANEL SHALL ADVISE NONPROFIT HEALTH CARE CORPORATIONS AND HEALTH CARE PROVIDERS ABOUT THE EFFICACY AND APPROPRIATENESS OF OFF-LABEL PATIENT TREATMENTS AND, WITHIN 2 YEARS OF THE EFFECTIVE DATE OF THIS SECTION, SUBMIT TO THE COMMISSIONER AND TO THE SENATE AND HOUSE OF REPRESENTATIVES

STANDING COMMITTEES ON INSURANCE ISSUES A REPORT OF ITS FINDINGS AND RECOMMENDATIONS.

SEC. 501B. (1) AT LEAST 7 DAYS BEFORE EXECUTING A PARTICIPATING CONTRACT WITH A PARTICIPATING PROVIDER, A HEALTH CARE CORPORATION SHALL MAKE AVAILABLE TO THAT PARTICIPATING PROVIDER A LIST IDENTIFYING ALL HEALTH CARE SERVICES FOR WHICH THE HEALTH CARE CORPORATION WILL REIMBURSE THE PARTICIPATING PROVIDER PURSUANT TO THE PARTICIPATING CONTRACT.

(2) NOT LATER THAN 60 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION, A HEALTH CARE CORPORATION SHALL PROVIDE A LIST DESCRIBED IN SUBSECTION (1) TO EACH PARTICIPATING PROVIDER THAT DID NOT RECEIVE THE LIST PURSUANT TO SUBSECTION (1) AND WITH WHOM THAT HEALTH CARE CORPORATION HAS AN ENFORCEABLE PARTICIPATING CONTRACT.