

SENATE BILL No. 432

July 11, 1991, Introduced by Senators SCHWARZ, EMMONS, EHLERS, DE GROW, DUNASKISS, N. SMITH, MC MANUS, PRIDNIA, WARTNER, CARL, ARTHURHULTZ and CISKY and referred to the Committee on Commerce.

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:

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

1 550.1509, 550.1510, 550.1511, and 550.1513 of the Michigan
2 Compiled Laws, are amended and sections 402b, 402c, 403b, 403c,
3 403d, 403e, 405a, 405b, 407a, 407b, 407c, 407d, and 408a are
4 added to read as follows:

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

14 (2) Four voting members of the board shall be representa-
15 tives of the public AND 2 VOTING MEMBERS OF THE BOARD SHALL BE
16 REPRESENTATIVES OF HEALTH CARE CONSUMERS. THE 6 REPRESENTATIVES
17 UNDER THIS SUBSECTION SHALL BE appointed by the governor by and
18 with the advice and consent of the senate. Two of ~~these~~ THE 4
19 PUBLIC members shall be retired individuals 62 years of age or
20 older. The term of office of each representative ~~of the public~~
21 UNDER THIS SUBSECTION shall be 2 years, and until a successor is
22 appointed and qualified. If a vacancy occurs before the conclu-
23 sion of a 2-year term, the appointment of a representative to
24 complete the term shall be made in the same manner as the origi-
25 nal appointment.

26 (3) The board of directors shall consist of ~~not more than~~
27 ~~25%~~ 33% provider directors. In addition to physician and

1 hospital provider directors, not less than 1 provider director
2 shall be a registered professional nurse who shall be representa-
3 tive of licensees under part 172 of the public health code, Act
4 No. 368 of the Public Acts of 1978, as amended, being sections
5 333.17201 to 333.17242 of the Michigan Compiled Laws, and not
6 less than 1 provider director shall be representative of the pro-
7 vider whose services, in the 1984 calendar year in the case of an
8 existing health care corporation, or, in the calendar year imme-
9 diately following incorporation in the case of a newly-formed
10 health care corporation, generated the largest number of benefit
11 claims received by the corporation from its subscribers. Other
12 provider directors shall be as broadly representative of provider
13 classes as possible.

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

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

19 (A) REPRESENTATIVES of large subscriber groups, medium sub-
20 scriber groups, small subscriber groups, and nongroup subscrib-
21 ers, in proportions which fairly represent the total subscriber
22 population of the health care corporation. However, at least 3
23 directors shall represent nongroup subscribers, at least 1 of
24 whom shall be a retired individual 62 years of age or older, and
25 at least 3 directors shall represent small subscriber groups.
26 Large and medium subscriber groups shall be represented, to the
27 greatest extent possible, by an equal number of labor and

1 management representatives and shall be categorized as labor
2 subscriber representatives or management subscriber
3 representatives.

4 (B) ONE REPRESENTATIVE FROM THE NATIONAL FEDERATION OF INDE-
5 PENDENT BUSINESSES, MICHIGAN CHAPTER.

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

8 (6) The method of selection of the directors, other than the
9 directors who are representatives of the public, and additional
10 provisions and requirements for further refinement or specifica-
11 tion regarding the number of directors comprising each component
12 shall be specified in the bylaws. The terms of office of direc-
13 tors, other than the directors who are representatives of the
14 public, and the method for filling vacancies in those offices
15 shall be provided in the bylaws. However, if a term of office of
16 more than 1 year is prescribed by the bylaws, at least 1/3 of the
17 members of the board shall be selected each year.

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

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

7 (8) For the purposes of this section:

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

9 (i) A person defined as a health care provider or provider
10 in section 105(4); a person employed by a health care facility,
11 as defined in section 105(3); or a director, officer, or trustee
12 of a health care provider, as defined in section 105(4), unless
13 the person serves in that capacity as a representative selected
14 by the same subscriber group or collective bargaining representa-
15 tive which the person represents on the board of a health care
16 corporation.

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

20 (iii) A person who receives more than 25% of his or her
21 annual income through the provision of goods or services to
22 health care providers, or who is an employee, officer, trustee,
23 or director of a firm or organization which receives more than
24 25% of its annual income through the provision of goods or serv-
25 ices to health care providers.

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

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

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

6 (ii) The term of office of the director commences in the
7 1988 calendar year.

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

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

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

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

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

19 (B) FOUR PROVIDER REPRESENTATIVES APPOINTED BY THE
20 COMMISSIONER.

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

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

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

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

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

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

9 (7) THE REVIEW BOARD'S FIRST MEETING SHALL BE CALLED WITHIN
10 30 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION. AT THE FIRST
11 MEETING, THE REVIEW BOARD SHALL ELECT FROM AMONG ITS MEMBERS A
12 CHAIRPERSON AND OTHER OFFICERS AS IT CONSIDERS NECESSARY OR
13 APPROPRIATE. AFTER THE FIRST MEETING, THE REVIEW BOARD SHALL
14 MEET AT LEAST QUARTERLY OR MORE FREQUENTLY AT THE CALL OF THE
15 CHAIRPERSON.

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

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

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

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

3 (11) REVIEW BOARD MEMBERS SHALL SERVE WITHOUT COMPENSATION.
4 HOWEVER, REVIEW BOARD MEMBERS MAY BE REIMBURSED FOR THEIR ACTUAL
5 AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR OFFI-
6 CIAL DUTIES AS REVIEW BOARD MEMBERS.

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

8 (A) REVIEW AND MAKE RECOMMENDATIONS CONCERNING PREAUTHORIZA-
9 TION PROCEDURES.

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

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

14 (D) PREPARE ANNUALLY AND DISTRIBUTE TO THE HEALTH CARE COR-
15 PORATION AND THE SENATE AND HOUSE OF REPRESENTATIVES' STANDING
16 COMMITTEES ON HEALTH AND INSURANCE ISSUES A REPORT ON SUBDIVI-
17 SIONS (A) THROUGH (C).

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

21 SEC. 403B. NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT,
22 FOR THE SAME HEALTH CARE SERVICE BY THE SAME CLASS OF PROVIDERS,
23 A HEALTH CARE CORPORATION SHALL REIMBURSE A SUBSCRIBER OR PARTIC-
24 IPATING OR NONPARTICIPATING HEALTH CARE PROVIDER AT THE SAME RATE
25 REGARDLESS OF GEOGRAPHIC LOCATION.

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

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

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

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

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

1 REQUIREMENTS, BENEFIT PLAN LIMITATIONS, AND ELIGIBILITY

2 REQUIREMENTS.

3 SEC. 403E. EACH HEALTH CARE CORPORATION SHALL DISCLOSE LIM-
4 ITATIONS AND ELIGIBILITY REQUIREMENTS OF A BENEFIT PLAN IN ALL
5 ADVERTISING AND MARKETING MATERIALS FOR THAT PLAN.

6 SEC. 405A. EACH HEALTH CARE CORPORATION SHALL ESTABLISH AND
7 MAINTAIN A LIAISON COMMITTEE WITH PROVIDERS ON CLAIM FORM DEVEL-
8 OPMENT AND USE. THE LIAISON COMMITTEE SHALL PROVIDE INFORMATION
9 ON PROPER SUBMISSION OF CLAIMS DIRECTLY TO PROVIDERS AND FOR DIS-
10 TRIBUTION THROUGH THE MEETINGS HELD PURSUANT TO SECTION 405B.

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

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

1 reimbursement; denial, cancellations, or nonrenewals of
2 certificates; and complaints regarding the quality of the serv-
3 ices delivered by health care providers and health care facili-
4 ties ~~which~~ THAT receive reimbursement from the corporation.

5 (2) A health care corporation, within 30 days after receipt
6 of written complaint, shall give a reasonable written response to
7 each written complaint ~~which~~ THAT it receives. The commis-
8 sioner shall have free access, as defined in section 603(2), to
9 complaints and responses, which shall be made available to the
10 commissioner for inspection. If the matter complained of is rea-
11 sonably believed by the complainant to be a violation of section
12 402 or 403, the complainant shall be entitled to a private infor-
13 mal managerial-level conference with the health care corporation,
14 as provided for in section 404.

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

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

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

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

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

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

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

16 (C) WHETHER HEALTH CARE CORPORATION EMPLOYEES IDENTIFY THEM-
17 SELVES TO CALLERS.

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

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

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

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

17 (5) THE COMMISSIONER SHALL PREPARE A REPORT ON THE
18 COMMISSIONER'S FINDINGS UNDER SUBSECTION (4), SHALL COMPARE THE
19 FINDINGS TO THE THE FINDINGS IN THE REPORT PREPARED UNDER
20 SUBSECTION (2), SHALL MAKE RECOMMENDATIONS ON MEANS TO IMPROVE
21 THE FINDINGS WITHIN 30 DAYS AFTER THE COMPLETION OF THE AUDIT,
22 AND SHALL DISTRIBUTE THE REPORT TO THE HEALTH CARE CORPORATION
23 AND TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMIT-
24 TEES ON HEALTH AND INSURANCE ISSUES.

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

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

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

7 (A) ONE REPRESENTATIVE OF HEALTH CARE PROVIDERS. IF THE
8 APPEAL IS BROUGHT BY A HEALTH CARE PROVIDER, THE HEALTH CARE PRO-
9 VIDER APPEALS BOARD REPRESENTATIVE SHALL BE A STATE LICENSED AND
10 PRACTICING MEMBER OF THE SAME PROFESSION AS THE PROVIDER THAT
11 BROUGHT THE APPEAL OR IF THE PROVIDER THAT BROUGHT THE APPEAL IS
12 BOARD CERTIFIED, SHALL BE A STATE LICENSED AND PRACTICING MEMBER
13 OF THE SAME PROFESSION WHO IS ALSO BOARD CERTIFIED IN THE SAME
14 AREA AS THE PROVIDER THAT BROUGHT THE APPEAL. AS USED IN THIS
15 SUBDIVISION, "PRACTICING" MEANS EARNING 75% OF ANNUAL INCOME FROM
16 ACTIVE PATIENT CARE IN THIS STATE.

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

19 (3) THE COMMISSIONER SHALL ESTABLISH THE APPROPRIATE NUMBER
20 OF APPEALS BOARDS UNDER SUBSECTION (1) AS THE COMMISSIONER CON-
21 SIDERS NECESSARY.

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

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

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

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

6 SEC. 407D. THE COMMISSIONER SHALL AUDIT ANNUALLY THE OPERA-
7 TION OF A HEALTH CARE CORPORATION TO DETERMINE IF THE HEALTH CARE
8 CORPORATION IS COMPLYING WITH SECTIONS 402C, 403B, 403C, 403D,
9 403E, 405A, 405B, AND 407C. IF THE COMMISSIONER FINDS AFTER A
10 HEARING HELD IN COMPLIANCE WITH THE ADMINISTRATIVE PROCEDURES ACT
11 THAT THE HEALTH CARE CORPORATION IS NOT COMPLYING WITH
12 SECTIONS 402C, 403B, 403C, 403D, 403E, 405A, 405B, OR 407C, THE
13 COMMISSIONER MAY IMPOSE UPON THE HEALTH CARE CORPORATION A CIVIL
14 FINE OF NOT MORE THAN \$5,000.00 FOR EACH VIOLATION.

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

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

18 (A) ONE REPRESENTATIVE OF THE HEALTH CARE CORPORATION.

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

21 (C) ONE REPRESENTATIVE FROM THE BUREAU OF HEALTH.

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

23 (E) TWO PROVIDER REPRESENTATIVES APPOINTED BY THE
24 COMMISSIONER.

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

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

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

9 (5) A MAJORITY OF THE FRAUD REVIEW PANEL'S MEMBERS CONSTI-
10 TUTES A QUORUM FOR THE TRANSACTION OF BUSINESS AT A FRAUD REVIEW
11 PANEL MEETING. A MAJORITY OF THE MEMBERS PRESENT AND SERVING IS
12 REQUIRED FOR OFFICIAL ACTION OF THE FRAUD REVIEW PANEL.

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

17 (7) A WRITING PREPARED, OWNED, USED, IN POSSESSION OF, OR
18 RETAINED BY THE FRAUD REVIEW PANEL IN PERFORMANCE OF AN OFFICIAL
19 FUNCTION IS SUBJECT TO THE FREEDOM OF INFORMATION ACT, ACT
20 NO. 442 OF THE PUBLIC ACTS OF 1976, BEING SECTIONS 15.231 TO
21 15.246 OF THE MICHIGAN COMPILED LAWS.

22 (8) FRAUD REVIEW PANEL MEMBERS SHALL SERVE WITHOUT
23 COMPENSATION. HOWEVER, FRAUD REVIEW PANEL MEMBERS MAY BE REIM-
24 BURSED FOR THEIR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE
25 PERFORMANCE OF THEIR OFFICIAL DUTIES AS FRAUD REVIEW PANEL
26 MEMBERS.

1 (9) THE FRAUD REVIEW PANEL SHALL EXAMINE THE HEALTH CARE
2 CORPORATION'S CURRENT FRAUD PREVENTION AND DETECTION SYSTEM AND
3 SHALL MAKE RECOMMENDATIONS ON WHAT ARE AND WHAT ARE NOT EFFECTIVE
4 FRAUD PREVENTION AND DETECTION SYSTEMS, INCLUDING, BUT NOT
5 LIMITED TO, THE USE OF PROFILES AND STATISTICAL MODELS, SURVEIL-
6 LANCE, AND DRUG UTILIZATION. THE FRAUD REVIEW PANEL SHALL PRE-
7 PARE AND DISTRIBUTE TO THE HEALTH CARE CORPORATION AND THE SENATE
8 AND HOUSE OF REPRESENTATIVES' STANDING COMMITTEES ON HEALTH AND
9 INSURANCE ISSUES A REPORT ON THE FRAUD REVIEW PANEL'S FINDINGS
10 AND RECOMMENDATIONS BY NOT LATER THAN 1 YEAR AFTER THE EFFECTIVE
11 DATE OF THIS SECTION.

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

21 (a) That the provider will accept payment from the corpora-
22 tion as payment in full for services rendered for the specified
23 claim for the member indicated.

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

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

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

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

16 (3) A health care corporation shall not restrict the methods
17 of diagnosis or treatment of professional health care providers
18 who treat members. Except as otherwise provided in section 502a,
19 each member of the health care corporation shall at all times
20 have a choice of professional health care providers. This sub-
21 section shall not apply to limitations in benefits contained in
22 certificates, to the reimbursement provisions of a provider con-
23 tract or reimbursement arrangement, nor to standards set by the
24 corporation for all contracting providers. A health care corpo-
25 ration may refuse to reimburse a health care provider for health
26 care services ~~which~~ THAT are overutilized, including those

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

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

17 (5) A health care corporation shall provide a symbol of par-
18 ticipation ~~—, which~~ THAT can be publicly displayed ~~—,~~ to pro-
19 viders who participate on all claims for covered health care
20 services rendered to subscribers.

21 (6) This section shall not be construed to impede the lawful
22 operation of, or lawful promotion of, a health maintenance orga-
23 nization owned by a health care corporation.

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

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

1 basis of ownership if the facility meets the reasonable standards
2 set by the health care corporation for similar facilities.
3 ~~is~~ NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, A HEALTH
4 CARE CORPORATION SHALL NOT DENY PARTICIPATION TO A FREESTANDING
5 MEDICAL OR SURGICAL OUTPATIENT FACILITY ON THE BASIS THAT THE
6 FACILITY IS NOT licensed under part 208 of the public health
7 code, Act No. 368 of the Public Acts of 1978, being sections
8 333.20801 to 333.20821 of the Michigan Compiled Laws, ~~and~~
9 ~~complies~~ OR DOES NOT COMPLY with part ~~221~~ 222 of the public
10 health code, Act No. 368 of the Public Acts of 1978, as amended,
11 being sections ~~333.22101 to 333.22181~~ 333.22201 TO 333.22260 of
12 the Michigan Compiled Laws, IF THE DEPARTMENT OF PUBLIC HEALTH
13 OTHERWISE PERMITS THE OPERATION OF THE FACILITY.

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

1 (2) Upon receipt of a provider class plan, the commissioner
2 shall examine the plan and shall determine only if the plan con-
3 tains a reimbursement arrangement and objectives for each goal
4 provided in section 504, and, for those providers with which a
5 health care corporation contracts, provisions that are included
6 in that contract. For purposes of making the determination
7 required by this subsection only, the commissioner shall liber-
8 ally construe the items contained in a provider class plan.

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

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

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

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

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

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

11 (2) A modification made under subsection (1) shall not
12 extend the time periods provided in section 509(1). In develop-
13 ing plan modifications, a health care corporation shall obtain
14 advice and consultation from providers in the relevant provider
15 class and from subscribers pursuant to section 505. Before
16 agreeing to plan modifications under subsection (1)(b), the com-
17 missioner shall obtain advice and consultation FROM THE SENATE
18 AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND
19 INSURANCE ISSUES AND pursuant to section 505(2).

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

24 (a) For a provider contract or a reimbursement arrangement
25 that was in effect prior to the effective date of this act, upon
26 the expiration of 2 years after the filing date under section
27 506.

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

5 (c) For a class plan retained by the commissioner as pro-
6 vided in section 506(4) that has not been subject to a determina-
7 tion under this section within the time period provided in sub-
8 section (2), within 2 years after the expiration of that time
9 period.

10 (2) Before making a determination under subsection (1), and
11 not later than 30 days following expiration of the appropriate
12 2-year time period described in subsection (1)(a), (b), or (c),
13 the commissioner shall give written notice to the health care
14 corporation, TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING
15 COMMITTEES ON HEALTH AND INSURANCE ISSUES, and to each person who
16 has requested a copy of such notice, that he or she intends to
17 make a determination with respect to a particular provider class
18 plan. The commissioner shall have 6 months to reach a determina-
19 tion under subsection (1).

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

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

25 (a) Annual reports transmitted pursuant to section 517.

26 (b) The overall balance of the goals provided in section
27 504, achieved by the health care corporation under the plan. The

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

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

15 (d) Health care legislation of this state or of the federal
16 government. As used in this subdivision, "health care
17 legislation" does not include THE INSURANCE CODE OF 1956, Act
18 No. 218 of the Public Acts of 1956, as amended, being sections
19 500.100 to 500.8302 of the Michigan Compiled Laws.

20 (e) Comments received from an individual provider of the
21 appropriate provider group, or from an organization or associa-
22 tion that represents the appropriate provider class, COMMENTS
23 RECEIVED BY THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COM-
24 MITTEES ON HEALTH AND INSURANCE ISSUES, and comments received
25 pursuant to section 505(2).

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

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

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

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

12 (8) Determinations by the commissioner shall not be con-
13 tested case hearings under chapter 4 of the administrative proce-
14 dures act. This subsection shall not be construed to apply with
15 respect to appeals under section 515.

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

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

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

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

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

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

13 (3) An existing provider contract or reimbursement arrange-
14 ment shall remain in effect until a new provider class plan has
15 been retained and placed into effect as provided in section
16 506(4). A provider class plan shall not be subject to further
17 review until the expiration of the time period provided in sec-
18 tion 509(1).

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

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

1 ISSUES a provider class plan that substantially achieves the
2 goals, achieves the objectives, and substantially overcomes the
3 deficiencies enumerated in the findings made by the commissioner
4 pursuant to section 510(2). In developing a provider class plan
5 under this subsection, the corporation shall obtain advice and
6 consultation from THE SENATE AND HOUSE OF REPRESENTATIVES STAND-
7 ING COMMITTEES ON HEALTH AND INSURANCE ISSUES AND FROM providers
8 in the provider class and subscribers, using procedures estab-
9 lished pursuant to section 505.

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

15 Sec. 513. (1) Upon receipt of a provider class plan under
16 section 511(1), the commissioner, after considering the informa-
17 tion and factors described in section 509(4), within 90 days
18 shall examine the plan and determine if the plan substantially
19 achieves the goals, achieves the objectives, and substantially
20 overcomes the deficiencies enumerated in the findings made by the
21 commissioner. If the commissioner determines that the plan sub-
22 stantially achieves the goals, achieves the objectives, and sub-
23 stantially overcomes the deficiencies enumerated in the findings
24 made by the commissioner, the plan shall be automatically
25 retained and placed into effect as provided in section 506.

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

1 and does not substantially overcome the deficiencies enumerated
2 in the findings made by the commissioner pursuant to section
3 510(2), the commissioner shall do all of the following:

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

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

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