HOUSE BILL No. 4594

April 1, 1993, Introduced by Rep. Hill and referred to the Committee on Insurance.

A bill to amend sections 2239, 2243, 3406a, 3406b, 3425, 3475, 3612, 3613, and 3614 of Act No. 218 of the Public Acts of 1956, entitled as amended

"The insurance code of 1956,"

section 2239 as added by Act No. 291 of the Public Acts of 1982, sections 3406a and 3613 as added by Act No. 527 of the Public Acts of 1982, sections 3406b and 3614 as added and section 3475 as amended by Act No. 280 of the Public Acts of 1984, section 3425 as added by Act No. 429 of the Public Acts of 1980, and section 3612 as added by Act No. 259 of the Public Acts of 1989, being sections 500.2239, 500.2243, 500.3406a, 500.3406b, 500.3425, 500.3475, 500.3612, 500.3613, and 500.3614 of the Michigan Compiled Laws; and to add sections 2240 and 3406f.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 2239, 2243, 3406a, 3406b, 3425, 3475, 3612, 3613, and 3614 of Act No. 218 of the Public Acts of 1956, section 2239 as added by Act No. 291 of the Public Acts of 1982, sections 3406a and 3613 as added by Act No. 527 of the Public Acts of 1982, sections 3406b and 3614 as added and section 3475 as amended by Act No. 280 of the Public Acts of 1984, section 3425 as added by Act No. 429 of the Public Acts of 1980, and section 3612 as added by Act No. 259 of the Public Acts of 1989, being sections 500.2239, 500.2243, 500.3406a, 500.3406b, 500.3425, 500.3475, 500.3612, 500.3613, and 500.3614 of the Michigan Compiled Laws, are amended and sections 2240 and 3406f are added to read as follows:

Sec. 2239. (1) If a group or individual hospital, medical, or expense incurred policy delivered, issued for delivery, or renewed in this state provides for benefits for a health care service, those benefits or reimbursement for the provision of the service shall not be denied because the service was rendered by a dentist, provided the service was legally performed.

(2) As used in this section, "dentist" means an individual licensed under part 166 of Act No. 368 of the Public Acts of 1978, being sections 333.16601 to ~~333.16647~~ 333.16648 of the Michigan Compiled Laws.

(3) This section ~~shall apply~~ APPLIES only with respect to policies issued or renewed on or after ~~the effective date of this section, and shall apply~~ OCTOBER 7, 1982 AND APPLIES notwithstanding any policy provision to the contrary. THIS SECTION

DOES NOT APPLY TO A POLICY OR CERTIFICATE ISSUED PURSUANT TO SECTION 3406F.

SEC. 2240. (1) EACH DISABILITY INSURER AND EACH SELF-INSURED HEALTH PLAN SHALL REQUIRE THAT ONLY THE STANDARD MEDICAL CLAIM FORM ESTABLISHED PURSUANT TO SUBSECTION (2) BE USED BEFORE A CLAIM IS PAID.

(2) THE COMMISSIONER SHALL PROMULGATE RULES 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, ESTABLISHING, IN PLAIN ENGLISH, A STANDARD MEDICAL CLAIM FORM TO BE USED BY EACH DISABILITY INSURER, EACH HEALTH CARE CORPORATION, AND EACH HEALTH MAINTENANCE ORGANIZATION. THE STANDARD MEDICAL CLAIM FORM SHALL REQUIRE PROVIDERS TO LIST EACH PROCEDURE AND SERVICE PERFORMED PURSUANT TO THE CODE IDENTIFIED FOR THAT PROCEDURE OR SERVICE IN THE <u>INTERNATIONAL CLASSIFICATION OF CLINICAL SERVICES</u> BY THE COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES.

(3) ALL BILLING FOR HEALTH CLAIMS FOR A DISABILITY INSURER OR SELF-FUNDED HEALTH PLAN SHALL BE DONE THROUGH REGIONAL CLAIMS CENTERS TO REDUCE ADMINISTRATIVE EXPENSES.

(4) THE FIRST OF THE FOLLOWING ENTITIES TO RECEIVE A HEALTH CARE CLAIM IS RESPONSIBLE FOR COORDINATING THE REIMBURSEMENT FOR THAT CLAIM WITH ANY OTHER OF THE FOLLOWING ENTITIES THAT MAY BE RESPONSIBLE FOR THAT CLAIM:

(A) AN INSURER.

(B) A SELF-FUNDED HEALTH PLAN.

(C) A HEALTH CARE CORPORATION.

(D) A HEALTH MAINTENANCE ORGANIZATION.

(E) THE MEDICAL SERVICES ADMINISTRATION OF THE DEPARTMENT OF SOCIAL SERVICES.

(5) THIS SECTION SHALL TAKE EFFECT OCTOBER 1, 1994.

Sec. 2243. (1) Notwithstanding any provision of a policy or contract of group accident, group health or group accident and health insurance, executed ~~subsequently to the effective date of this provision, whenever such~~ AFTER JULY 23, 1965, IF A policy or contract provides for reimbursement for any optometric service ~~which~~ THAT is within the lawful scope of practice of a duly licensed optometrist, a subscriber to ~~such~~ THE group accident, group health, or group accident and group health insurance policy or contract ~~shall be~~ IS entitled to reimbursement for ~~such~~ THE service, whether the ~~said~~ service is performed by a physician or a duly licensed optometrist. Unless ~~such~~ THE policy or contract of group accident, ~~or~~ group health, or group accident and health insurance ~~shall~~ otherwise ~~provide~~ PROVIDES, there ~~shall be~~ IS no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances.

(2) ~~Whenever~~ IF a subscriber contract ~~shall provide~~ PROVIDES for and ~~offer~~ OFFERS optometric services, the subscriber ~~shall have freedom of choice to~~ MAY select either a physician or an optometrist to render ~~such~~ THE services. Unless ~~such~~ THE subscriber contract ~~shall~~ otherwise ~~provide~~ PROVIDES, there ~~shall be~~ IS no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances.

(3) THIS SECTION DOES NOT APPLY TO A POLICY OR CERTIFICATE ISSUED PURSUANT TO SECTION 3406F.

Sec. 3406a. ~~A~~ AN EXPENSE-INCURRED hospital, medical, or surgical ~~expense incurred~~ policy shall offer benefits for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this section. THIS SECTION DOES NOT APPLY TO A POLICY OR CERTIFICATE ISSUED PURSUANT TO SECTION 3406F.

Sec. 3406b. A policy or certificate ~~which~~ THAT provides coverage for mental health services shall provide coverage for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the insurer for all other providers of the type. THIS SECTION DOES

NOT APPLY TO A POLICY OR CERTIFICATE ISSUED PURSUANT TO SECTION 3406F.

SEC. 3406F. (1) AN INSURER MAY OFFER A BASIC HEALTH POLICY OR CERTIFICATE SUBJECT TO ALL OF THE FOLLOWING:

(A) COSTS NOT MORE THAN $75.00 PER MONTH FOR GROUP INDIVIDUAL COVERAGE AND $90.00 PER MONTH FOR INDIVIDUAL COVERAGE AND NOT MORE THAN $120.00 PER MONTH FOR GROUP FAMILY COVERAGE AND $180.00 PER MONTH FOR INDIVIDUAL FAMILY COVERAGE. THIS MONTHLY FEE SHALL BE ADJUSTED EACH YEAR PURSUANT TO THE ANNUAL AVERAGE PERCENTAGE INCREASE OR DECREASE IN THE CONSUMER PRICE INDEX AND THE PERCENTAGE INCREASE OR DECREASE IN UTILIZATION. THE ADJUSTMENT SHALL BE MADE BY MULTIPLYING THE CURRENT MONTHLY FEE AS PREVIOUSLY ADJUSTED BY THIS SUBDIVISION BY THE PRODUCT OF THE ANNUAL AVERAGE PERCENTAGE INCREASE OR DECREASE IN THE CONSUMER PRICE INDEX FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR AND THE PERCENTAGE INCREASE OR DECREASE IN SERVICES PER 1,000 MEMBERS FROM 1 YEAR TO THE NEXT. THE RESULTANT PRODUCT SHALL BE ADDED TO THE MONTHLY FEE AS PREVIOUSLY ADJUSTED BY THIS SUBDIVISION AND THEN ROUNDED OFF TO THE NEAREST WHOLE NUMBER, WHICH SHALL BE THE NEW MONTHLY FEE FOR THE CURRENT YEAR. AS USED IN THIS SUBDIVISION, "CONSUMER PRICE INDEX" MEANS THE ANNUAL AVERAGE PERCENTAGE INCREASE IN THE CONSUMER PRICE INDEX FOR ALL ITEMS FOR THE PRIOR 12-MONTH PERIOD AS REPORTED BY THE UNITED STATES DEPARTMENT OF LABOR, BUREAU OF LABOR AND STATISTICS AND AS CERTIFIED BY THE COMMISSIONER.

(B) HAS BEEN APPROVED BY THE COMMISSIONER AS PROVIDING COVERAGE THAT IS REASONABLE IN RELATION TO THE PREMIUM CHARGED.

(C) CONTAINS COVERAGE FOR DOCTOR OFFICE VISITS, WELL CHILD CARE, MEDICALLY NECESSARY DIAGNOSTIC TESTS, OUTPATIENT SURGERY AND ANESTHESIA, MATERNITY CARE, AND COVERAGE SUCH AS EMERGENCY CARE, IMMUNIZATIONS, PRESCRIPTION DRUGS, URGENT AND EMERGENT SURGERY, AND ANESTHESIA. DOCTOR OFFICE VISITS AND WELL CHILD CARE SHALL BE SUBJECT TO NOT MORE THAN 20% COPAYS AND DEDUCTIBLES, AND MAY BE SUBJECT TO REASONABLE COVERAGE LIMITATIONS. OTHER BENEFITS MAY BE SUBJECT TO REASONABLE COPAYS, DEDUCTIBLES, AND COVERAGE LIMITATIONS.

(D) IF OFFERED TO AN EMPLOYER FOR HIS OR HER EMPLOYEES, DOES NOT LIMIT OR EXCLUDE ANY EMPLOYEE IN A COVERED CLASS OF EMPLOYEES IN THE INITIAL OFFERING.

(2) AN INSURER MAY OFFER ALTERNATIVE BASIC HEALTH POLICIES OR CERTIFICATES WITH VARIOUS COVERAGES, DEDUCTIBLES, COPAYS, AND BENEFIT LIMITATIONS PROVIDED THAT EACH BASIC HEALTH POLICY OR CERTIFICATE SATISFIES SUBSECTION (1).

(3) THE COMMISSIONER SHALL ENCOURAGE AND PROMOTE THE DEVELOPMENT OF BASIC HEALTH POLICIES AND CERTIFICATES UNDER THIS SECTION.

(4) AS USED IN THIS SECTION, "EMERGENCY CARE" MEANS TREATMENT FOR A CONDITION THAT OCCURS SUDDENLY AND UNEXPECTEDLY AND MAY RESULT IN SERIOUS BODILY HARM OR BE LIFE THREATENING UNLESS TREATED IMMEDIATELY AND MAY INCLUDE AMBULANCE SERVICES TO A HEALTH CARE FACILITY.

Sec. 3425. (1) Each insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in

all contracts for, group and individual EXPENSE-INCURRED hospital, medical, OR surgical ~~expense incurred~~ health insurance policies other than limited classification policies OR POLICIES OR CERTIFICATES ISSUED PURSUANT TO SECTION 3406F.

(2) ~~In the case of~~ FOR group health insurance policies, if the premium for a group health insurance policy would be increased by 3% or more because of the provision of the coverage required under subsection (1), the master policyholder shall have the option to decline the coverage required to be provided under subsection (1). ~~In the case of~~ FOR individual health insurance policies, if the total premium for all individual health insurance policies of an insurer would be increased by 3% or more because of the provision of the coverage required under subsection (1) in all of those policies, the named insured of each such policy shall have the option to decline the coverage required to be provided under subsection (1).

(3) Charges, terms, and conditions for the coverage required to be provided under subsection (1) shall not be less favorable than the maximum prescribed for any other comparable service.

(4) The coverage required to be provided under subsection (1) shall not be reduced by terms or conditions ~~which~~ THAT apply to other items of coverage in a health insurance policy, group or individual. This subsection shall not be construed to prohibit health insurance policies that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse.

(5) The coverage required to be provided under subsection (1) shall, at a minimum, provide for up to $1,500.00 in benefits for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(6) As used in this section:

(a) "Health insurance policy" means ~~a~~ AN EXPENSE-INCURRED hospital, medical, or surgical ~~expense incurred~~ policy.

(b) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) "Limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(d) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic

techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(e) "Substance abuse" means that term as defined in section 6107 of Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

~~(7) This section shall take effect January 1, 1982.~~

Sec. 3475. Notwithstanding any provision of any policy of insurance or certificate, if an insurance policy or certificate provides for reimbursement for any service ~~which~~ THAT may be legally performed by a person fully licensed as a psychologist under part 182 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.18201 to 333.18237 of the Michigan Compiled Laws; by a podiatrist licensed under part 180 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.18001 to 333.18033 of the Michigan Compiled Laws; by a chiropractor licensed under part 164 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16401 to 333.16431 of the Michigan Compiled Laws; reimbursement under the insurance policy or certificate shall not be denied if the service is rendered by a person fully licensed

as a psychologist under part 182 of the public health code, Act No. 368 of the Public Acts of 1978; by a podiatrist licensed under part 180 of the public health code, Act No. 368 of the Public Acts of 1978; or by a chiropractor licensed under part 164 of the public health code, Act No. 368 of the Public Acts of 1978; within the statutory provisions provided in his or her individual practice act. This section shall not be construed as requiring the coverage for a psychologist in any insurance policy. This section ~~shall~~ DOES not apply to a policy or certificate written pursuant to section 3405, 3631, or 3709 involving a prudent purchaser agreement OR TO A POLICY OR CERTIFICATE ISSUED PURSUANT TO SECTION 3406F.

Sec. 3612. (1) An expense-incurred hospital, medical, surgical, or sick-care group disability insurance policy issued or renewed in this state after December 31, 1990, shall include provisions consistent with this section.

(2) If an individual member has been continuously covered under a group policy for at least 3 months immediately prior to termination, the individual member and his or her covered spouse and dependents may elect coverage under an individual conversion policy upon termination. As used in this section, termination includes, but is not limited to, the following:

(a) Discontinuance of a group policy in its entirety or with respect to an insured class.

(b) Loss of expense-incurred hospital, medical, surgical, or sick-care insurance coverage due to voluntary or involuntary

termination of employment except for termination of employment because of gross misconduct.

(c) For a surviving spouse or dependent, death of an individual member covered under a group policy.

(d) An event that causes a person, who is a spouse or dependent of an individual member at the time of the event, to cease to be a qualified family member under a group policy.

(3) Coverage under an individual conversion policy shall take effect immediately upon the termination of coverage under the group policy.

(4) Notification of the conversion privilege shall be included in each policy and certificate of coverage.

(5) A group policyholder shall give written notice to an individual member of the option to elect an individual conversion policy within 14 days after the occurrence of subsection (2)(a) or (b).

(6) An individual member shall notify the insurer of his or her election to convert to an individual conversion policy not later than 30 days after termination of coverage. The first premium shall be paid to the insurer at the time the individual elects to convert to an individual conversion policy.

(7) An individual conversion policy under this section:

(a) Shall be issued without evidence of insurability.

(b) Shall not use conditions pertaining to health as a basis for classification.

(c) Shall not exclude a preexisting condition that is not excluded by the group policy solely because it is a preexisting condition.

(d) May provide that benefits may be reduced by the amount of benefits paid for a specific covered service pursuant to the group policy or certificate that has been terminated.

(8) The premium for an individual conversion policy under this section shall be determined using the aggregate experience for all such policies issued in this state by the insurer and in accordance with premium rates applicable to the age, class of risk, and the type and amount of coverage provided. The experience of an individual under an individual conversion policy shall not be an acceptable basis for establishing that individual's rate for his or her converted policy.

(9) An insurer is not required to issue an individual conversion policy under this section if any of the following circumstances apply:

(a) The individual is covered for similar benefits and to a similar extent by another expense-incurred hospital, medical, surgical, or sick-care insurance policy or certificate, hospital or medical service subscriber contract, medical practice or other prepayment plan, or other expense-incurred plan or program.

(b) The individual is covered under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, ~~1395i-1a to 1395i-3, 1395j to 1395dd, 1395ff to 1395mm, and 1395oo to 1395ccc~~ 1395i-2 TO 1395i-4, 1395j TO 1395t, 1395u TO 1395w-2, 1395w-4 TO 1395ccc.

(c) If termination of an individual's coverage under a group policy occurred because of any of the following:

(*i*) The individual failed to pay any required contribution.

(*ii*) Discontinued group coverage was replaced by group coverage.

(*iii*) The individual acted to defraud the insurer.

(D) THE INDIVIDUAL WAS COVERED IMMEDIATELY PRIOR TO TERMINATION BY A POLICY OR CERTIFICATE ISSUED PURSUANT TO SECTION 3406F.

(10) An individual conversion policy under this section delivered outside this state for a group policy that was issued and delivered in this state shall comply with this section.

Sec. 3613. ~~A~~ AN EXPENSE-INCURRED group hospital, medical, or surgical ~~expense incurred~~ policy OR CERTIFICATE shall provide benefits for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this section. THIS SECTION DOES NOT APPLY TO A POLICY OR CERTIFICATE ISSUED PURSUANT TO SECTION 3406F.

Sec. 3614. A policy or certificate ~~which~~ THAT provides coverage for mental health services shall provide coverage for

mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the insurer for all other providers of the type. THIS SECTION DOES NOT APPLY TO A POLICY OR CERTIFICATE ISSUED PURSUANT TO SECTION 3406F.

Section 2. This amendatory act shall take effect October 1, 1994.