House
Legislative
Analysis
Section

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PATIENT RIGHTS BILLS

House Bill 5570 as enrolled
Public Act 515 of 1996
Sponsor: Rep. Sharon Gire

House Bill 5571 as enrolled
Public Act 516 of 1996
Sponsor: Rep. Laura Baird

House Bill 5572 as enrolled
Public Act 517 of 1996
Sponsor: Rep. John Jamian

House Bill 5573 as enrolled
Public Act 472 of 1996
Sponsor: Rep. Penny Crissman

House Bill 5574 as enrolled
Public Act 518 of 1996
Sponsor: Rep. Gerald Law

House Committee: Health Policy
Senate Committee: Health Policy and Senior Citizens
Third Analysis (1-14-97)

THE APPARENT PROBLEM:

Legislation has been developed to address complaints that patients and health care providers have made about today's health care/health insurance marketplace, and in particular about so-called managed care plans. There has been a movement over the past decade toward managed care approaches, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and similar entities. Generally speaking, this has been a response to the high cost and ever increasing cost of health care, particularly by those who pay a large share of the tab for health benefits, such as employers and labor unions. Managed care plans aim at controlling costs, essentially by limiting choices and restricting access to care. (The standard argument against the traditional insurance system is that it contains incentives to provide too much care, such as unnecessary tests and surgeries.) A person who joins an HMO, for example, typically can visit only affiliated providers and must get authorization from a primary care provider (and often others in the organization) in order to see a specialist. Similar kinds of restrictions on where a person can get health care or related products, such as drugs and appliances, can be found in other managed care arrangements. (Patients are free to go outside of the approved list of providers, of course, but then must pay some or perhaps all of the cost themselves.)

Among the obvious consequences of managed care are that patients cannot in every case visit the providers they prefer or get the kind of treatment they believe they need, and providers cannot always become affiliated with health plans and so become shut out from a pool of patients, including patients of their own who are changing health plans. Sometimes patients and providers are required to end longstanding relationships. (Mental health practitioners complain this can be a serious problem when a course of counseling or therapy is disrupted.) Moreover, treatment decisions are no longer a matter to be decided by patient and provider alone but require the approval at other administrative levels. Physicians prescribing treatment plans resent having to seek approval and being second-guessed. Whenever there is a

"gatekeeper" who decides whether treatment is permissible under a health plan some patients are likely to find the gate closed to them despite their own (and sometimes even their physician's) understanding of their needs. Critics say this results in patients being denied medically necessary treatment (or coverage for it, which amounts in most cases to the same thing). Further, critics say, patients often do not understand their health benefit plans very well and are not aware that they may be entitled to care -- or some portion of the care -- that they are being denied. This is made worse when patients and providers have no realistic avenues of appeal when treatment coverage has been denied. And, sometimes people seek treatment, for example in emergency rooms, that they only later discover is not covered under their plans.

Another source of concern is the denial of coverage based on pre-existing conditions. When people join a health plan or change health plans, they may discover that they must wait a certain length of time for coverage of a condition or ailment for which they have previously been treated or they may find that the condition will not be covered at all. This is disastrous for people with serious chronic conditions requiring costly treatment and inconvenient for many others. It also can have a disproportionate effect on other decisions families must make, since leaving one health plan for another could lead to medical or financial crises. It also leads to people being unable to find coverage at all.

These and other issues have been addressed in a series of bills that have come to be known as "patient bill of rights."

THE CONTENT OF THE BILLS:

The bills, in general, would do the following.

-- Various insurance entities would have to provide plain English explanations of their policies or contracts to subscribers upon enrollment.

-- Prudent purchaser organizations (PPOs) and health maintenance organizations (HMOs) would be required to provide upon request to subscribers a clear, complete, and accurate description of certain specified aspects of their plans.

-- Commercial health insurance companies and HMOs would be required to establish internal formal grievance procedures for approval by the Insurance Bureau, and those entities and Blue Cross and Blue Shield of Michigan (whose governing statute already requires a grievance procedure) would be required to establish expedited grievance procedures where the life or health of subscribers were in acute jeopardy.

-- For a group policy covering more than 50 individuals, commercial health insurers could limit or exclude coverage for a pre-existing condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment but the limitation or exclusion could extend for no more than six months after the effective date of the policy or certificate. For smaller group policies and individual policies of commercial insurers the exclusion or limitation could apply to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment and could not extend for more than 12 months after the effective date of the coverage.

-- There could be no pre-existing condition exclusions or limitations for group certificates of Blue Cross and Blue Shield of Michigan or group contracts of health maintenance organizations. Non-group certificates and contracts could exclude or limit coverage for up to six months after the effective date of the coverage for conditions for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment.

-- PPOs and HMOs would be required to have a 60-day provider application period when first forming provider panels and at least one 60-day provider application period every four years during which providers could apply for membership on panels. The application periods would have to be advertised in a newspaper of general circulation and providers would have to be notified personally upon request.

House Bill 5570 and House Bill 5573 would each amend the HMO Act within the Public Health Code (MCL 333.21053c). House Bill 5571 would amend the Nonprofit Health Care Corporation Reform Act, which governs Blue Cross and Blue Shield of Michigan (MCL 550.1402 et al.). House Bill 5572 would amend the Insurance Code to apply to the expense-incurred hospital, medical, or surgical policies or certificates of commercial health insurers (MCL 500.2212 et al.). House Bill 5574 would amend the Prudent Purchaser Act (MCL 550.53 and 550.53a). The bills' provisions would take effect October 1, 1997.

A more detailed description of the provisions in the bills follows.

Explanation of Policy. By October 1, 1997, an insurance company, HMO, and Blue Cross and Blue Shield would have to provide a written form in plain English to customers upon enrollment describing the terms and

conditions of the certificate, contract, or policy. The form would have to provide a clear, complete, and accurate description of all the following, as applicable: the service area; covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs; emergency health coverages and benefits; out-of-area coverages and benefits; an explanation of customer financial responsibility for copayments, deductibles, and any other out-of-pocket expenses; provision for continuity of treatment in the event a provider's participation is terminated during the course of a customer's treatment by that specialist; and the telephone number to call to get information about customer grievance procedures.

Prudent Purchaser/ Health Maintenance Organization Information. By October 1, 1997, an insurance entity (including BCBSM) would be required to provide upon request to a subscriber for services offered under a prudent purchaser plan or under an HMO contract a clear, complete, and accurate description of any of the following that had been requested. (The information would be provided in writing if so requested.)

-- The current provider network in the service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which specialists will not accept new customers;

-- The professional credentials of all participating specialists, including relevant professional degrees, date of certification by the applicable nationally recognized boards and other professional bodies; and the names of licensed facilities where the provider has relevant privileges.

--The licensing verification telephone number for the Michigan Department of Consumer and Industry Services that can be used for getting information about disciplinary actions and formal complaints in the past three years.

-- Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

-- The nature of the financial relationships between the insurance entity and any closed provider panel including whether a fee-for-service arrangement exists or a capitation arrangement exists and whether payments to providers are based on standards of cost, quality, or patient satisfaction.

-- A telephone number and address to obtain from the entity additional information on the abovementioned items.

Grievance Procedure. Commercial health insurers and health maintenance organizations would be required to establish internal formal grievance procedures for approval by the Insurance Bureau. (The act governing Blue Cross and Blue Shield already contains provisions addressing this.) As part of these procedures, a written statement would have to be provided whenever an adverse determination was made containing the reason for the determination. ("Adverse determination" would refer to a determination that an admission, availability of care, continued stay, or other health care service had been reviewed and denied. Failure to respond in a timely manner to a request for a determination would constitute an adverse determination.) A written notification of the grievance procedures would have to be provided to a customer contesting an adverse determination.

A final determination would have to be made in writing by the insurer or HMO (and by BCBSM) no later than 90 days after the submission of a formal grievance. The timing for this 90 days could be tolled (temporarily suspended), however, for any period of time the customer is permitted to take under the grievance procedure. The procedure would also have to provide the customer with a right to a final hearing before the insurance commissioner (for insurance companies and BCBSM) or before the Department of Community Health (for HMOs).

The bill applying to commercial insurers (HB 5572) contains some additional requirements regarding a formal grievance procedure. It would require that the procedure: provide for a designated person responsible for administering the system; provide a designated person or telephone number for receiving complaints; ensure full investigation of a complaint; provide for timely notification to the insured as to the progress of an investigation; provide an insured the right to appear before the board of directors or designated committee or the right to a managerial-level conference to present a grievance; provide for notification to the insured of the results of the insurer's right to review of the grievance by the commissioner; provide summary data on the number and types of complaints filed; provide for periodic management and governing body review of the data to assure that appropriate actions have been taken; and provide for copies of all complaints and responses to be available at the principal office of the insurer for inspection by the Insurance Bureau for two years following the year the complaint was filed.

Expedited Grievance Procedure. Further, an insurance entity, including Blue Cross and Blue Shield, would be

required to establish an expedited grievance procedure to apply in cases in which the time frame for a normal grievance would acutely jeopardize the life or health of the subscriber. The expedited grievance procedure would have to be in place by October 1, 1997. A physician would have to substantiate, orally or in writing, that the normal grievance time frame would acutely jeopardize the life of the insured. An initial determination would have to be made not later than 72 hours after receipt of an expedited grievance. Within three business days after the initial determination by the insurance entity, the insured or a person authorized to act on the insured's behalf could request further review by the entity or for a determination of the matter by the insurance commissioner (for an insurance company or Blue Cross-Blue Shield) or the Department of Community Health (for an HMO). If further review is requested, a final determination would have to be made not later than 30 days after receipt of the request. Within 10 days after receipt of a final determination, the insured or authorized person could request a determination of the matter by the commissioner or department. If the initial or final determination was made orally, the insurance entity would have to provide written confirmation not later than two business days after the oral determination. The amendments would specify that the grievance procedure would not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

Commissioner's Grievance Procedure. House Bill 5572, which applies to commercial health insurers, would require the insurance commissioner to establish a procedure for a determination of a grievance reasonably calculated to resolve matters informally and as rapidly as possible, while protecting the interests of both the insured and the insurer. The procedure would not be a contested case under the Administrative Procedures Act and would not be appealable under that act. (Similar language already appears in the act governing BCBSM. However, that act also provides that if the corporation or a person disagrees with the determination of the commissioner or his or her designee, the commissioner or designee, at the request of either party, would have to hear the matter as a contested case under the APA.)

Opportunities for Providers to Apply for Panel Membership. Prudent provider organizations establishing panels and health maintenance organizations contracting with affiliated providers or offering prudent purchaser contracts would have to develop and institute procedures designed to notify providers of a particular covered health care service located in the geographic area served by the organization of the formation of a provider panel. The procedures would have to include: an initial 60-day provider application period during which providers could apply for membership on the provider panel and an additional 60-day application period at least every four years.

Notice of the application periods would have to be published in a newspaper with general circulation in the area served by the organization at least 30 days before the initial enrollment period and be given to providers upon request. Within 90 days after the close of an application period, or within 30 days following the completion of the applicable physician credentialling process, whichever was later, an organization would have to notify an applicant in writing as to whether he or she had been accepted or rejected for membership on the provider panel or as an affiliated provider. If the applicant had been rejected, the organization would have to state in writing the reasons for rejection, citing one or more of the standards. Further, a health care provider whose membership on a provider panel was terminated would have to be provided upon request with a written explanation of the reasons for the termination.

An organization providing prudent purchaser agreement services to an insurer would have to provide the insurer on a timely basis with information requested by an insurer that the organization had and that the insurer needed to comply with Section 2212 of the Insurance Code (which requires the insurer to provide certain information to customers).

House Bill 5570 would apply to HMO panels. House Bill 5574 would apply to PPO panels. House Bill 5570, moreover, contains provisions already found in the Prudent Purchaser Act and would incorporate them into the HMO Act within the Public Health Code. Those provisions would specifically permit HMOs to enter into contracts with one or more health professionals to control health care costs, assure appropriate utilization of health care services, and maintain quality of care, and allows them to limit the number of contracts entered into if the number of contracts is sufficient to assure reasonable levels of access to health care services for recipients of those services. The provisions also require the organization to give interested health professionals the opportunity to apply to become affiliated providers; require that contracts be based on written standards for maintaining quality health care, controlling health care costs, assuring appropriate utilization of services, and assuring reasonable levels of access to service. The standards are to be filed with the insurance commissioner or the Department of Community Health; however, the bill says that if the insurance commissioner or the department determines that the standards are duplicative of standards already filed by an HMO, the duplicative standards need not be filed.

Pre-Existing Conditions. Under House Bill 5572, for a group policy covering more than 50 individuals,

commercial health insurers could limit or exclude coverage for a pre-existing condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment but the limitation or exclusion could extend for no more than six months after the effective date of the policy or certificate. For smaller group policies and individual policies the exclusion or limitation could apply to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment and could not extend for more than 12 months after the effective date of the coverage.

Blue Cross and Blue Shield (in House Bill 5571) and HMOs (in House Bill 5573) could not exclude or limit coverage for a pre-existing condition for an individual covered under a group certificate or contract. For an individual covered under a nongroup certificate or contract, BCBSM could exclude or limit coverage for a condition only if the exclusion or limitation related to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within six months before enrollment but the limitation or exclusion could extend for no more than six months after the effective date of the certificate.

The insurance commissioner and the director of the Department of Community Health would be required to examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by pre-existing condition limitations or exclusions and report to the governor and the Senate and House committees on insurance and health policy issues by May 15, 1997. The report would have to include the commissioner's and director's findings and propose alternative mechanisms or a combination of mechanisms to credit prior continuous health care coverage. The report would have to address at a minimum the cost of crediting such coverages; the period of lapse or break in coverage, if any, permitted; the types and scope of prior health care coverages permitted to be credited; any exceptions or exclusions to such crediting of coverage; and a uniform method of certifying periods of prior creditable coverage.

Renewal or Continuation of Certificates. The bills would specify that, except as provided, BCBSM, commercial insurers, and HMOs would be required to renew or continue in force a nongroup certificate at the option of the individual and would be required to renew or continue in force a group certificate at the option of the sponsor of the plan. Guaranteed renewal would not be required in cases of fraud, intentional misrepresentation of material fact, lack of payment, the discontinuance by the corporation of a particular type of coverage in the market, or the movement out of the service area by the individual or group.

FISCAL IMPLICATIONS:

An analysis from the Department of Community Health says that the package will not increase its costs but will increase the administrative burden on the Insurance Bureau. (Departmental analysis dated 9-18-96)

ARGUMENTS:

For:

This package of bills represents an important first step in the expansion of patient rights. It represents a compromise agreement among many of the key elements in today's health benefit marketplace. While some people would prefer that more be done to protect consumers and providers from abuses in managed care, the package is an excellent beginning and has many positive features. The bills would make health care consumers better informed, better able to contest adverse decisions by health plans, and better able to get treatment covered when first joining a plan or switching from one plan to another. Well informed consumers with access to institutionalized formal grievance procedures will likely lead to better performing health benefit plans over the long run and less consumer (and provider) dissatisfaction. Among the beneficial aspects of this package of bills are:

** It would limit the use insurers could make of pre-existing conditions as the basis for limiting or excluding health care coverage. Commercial health insurers, for small group and individual policies, could only "look back" six months and then limit or exclude coverage for 12 months after the effective date of the policy. For large group policies, insurers could look back six-months but only limit or exclude coverage for six months. (Blue Cross and Blue Shield and HMOs already face greater restrictions on their use of pre-existing conditions.) This prevents people from being unable to obtain insurance for on-going medical conditions when switching from one policy to another or when purchasing a policy for the first time. It means fewer people will go without coverage for care that they need and that there will be less uncompensated care provided in emergency rooms. Getting the right care early in the progress of an illness or condition can lead to lower costs than delaying treatment until a crisis occurs.

** It requires that when people join a health plan they be given a "clear, complete, and accurate" description of the plan in plain English, including a description of what benefits are covered, what the individual is personally financially responsible for, what happens if a patient's health care provider ceases to be a participant in the plan, what the emergency health benefits are, and how to get information about the grievance procedures.

** It would require prudent purchaser (or preferred provider) plans and HMOs to provide a host of information upon request to a person in the plan. Information would have to be provided about the provider network, the credentials of providers, prior authorization requirements, limitations on services and drugs, and the nature of the financial relationships between the organization and its providers, among other things. Customers also would be provided with the telephone number to use in checking on the disciplinary history of providers and a number to use in getting additional information from the health plan.

** It would require the creation of formal grievance procedures and special expedited grievance procedures when the denial of treatment threatened the life or health of the patient. While some plans have grievance procedures in place now, this legislation would put the requirement in the Insurance Code (and add to existing requirements for Blue Cross and Blue Shield and HMOs), and it would ensure that certain timetables be met regarding decisions about coverage. People seeking medical treatment ought to have some avenue to protest adverse determinations and deserve speedy replies.

** Providers would have to be notified when provider panels were being formed by HMOs and PPOs, and those entities would have to have application periods of at least 60 days at least every four years. Further, providers who are not selected for panels would have to be told why they were not selected.

Response:

Some people believe the package does not go far enough in helping consumers get the medical care that they need and are currently being denied under some health plans. Critics of managed care around the country have advocated for proposals that would, among other things, prohibit "gag rules" that prevent providers from telling patients about all available treatment options; shift liability from providers to managed care entities when patient deterioration is the result of the treatment policies of a health plan; restrict the financial incentives that plans can use to influence provider behavior; and require plans to cover care or products available from any provider willing to comply with a plan's participation criteria or to cover care from outside providers for an additional fee. This package contains none of these provisions.

Against:

Earlier versions of this legislation had more valuable restrictions on the use of pre-existing conditions by commercial health insurance companies. The earlier proposal would have applied the six-month look back and six-month exclusion or limitation to individual policies. It also would have applied only to conditions that had recently required "active medical treatment" rather than to conditions that had been diagnosed or where treatment had been recommended. The present version is a significant retreat from the earlier proposal.

Response:

The package represents a useful compromise on the issue of pre-existing conditions and still goes farther than recent federal legislation. Representatives of commercial health insurance companies claimed that the pre-existing condition provisions in earlier versions of this package were harmful to them and, ultimately, to their customers. They were likely to increase costs to the companies, which would have meant higher premiums to customers. Many of the customers of commercial health insurers purchase their own insurance rather than participate in a company plan. Cost considerations are crucial for these people, who, according to industry representatives, are typically young people, self-employed, with moderate incomes. As the cost of insurance increases so does the likelihood that some people will have to drop their coverage. Draconian restrictions on pre-existing condition limitations and exclusions will leave those people worse off. It is also possible that some health insurers would then no longer market their policies in the state. The earlier pre-existing condition provision said that a company could only refuse to cover a condition that required active medical treatment during the six months before buying a policy and only for the first six months of the policy. That would have meant that a serious condition or one costly to treat that had been treated more than six months prior to the policy would have been covered immediately. That would be close to allowing people to buy coverage for health care at the very point at which they find out they need the care, which is contrary to the concept of insurance.

Against:

The restrictions on the use of pre-existing conditions, even in the modified form of the legislation as enacted, will still harm some consumers who purchase individual policies. They will make health insurance less available and/or less affordable, because some coverage will either not be available at all to consumers with past health problems or only at increased rates. The legislation will reduce the consumer's flexibility in designing coverages to reduce costs.

The mandatory grievance procedure provisions and the notification provisions will also tend to raise costs to insurance companies. While it sounds useful in principle to add to the information that must be provided to customers, is it realistic to expect that people will read and digest it? A great deal of information about health care plans is already available; how many people make good use of it? Further, the provision requiring policies to be renewable ignores the fact that some people

intentionally buy short-term policies that are designed (and priced) not to be renewable.

It also ought to be noted that these bills will not affect a significant portion of the health plans that cover consumers in Michigan because federal legislation pre-empts state regulation of self-insured health benefit plans. Many employees in Michigan are covered under employer-sponsored self-insurance plans.

Analyst: C. Couch

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.