Senate Fiscal Agency
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BILL ANALYSIS

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House Bill 5570 (Substitute H-2 as passed by the House)
House Bill 5571 (Substitute H-3 as passed by the House)
House Bill 5572 (Substitute H-2 as passed by the House)
House Bill 5573 (Substitute H-2 as passed by the House)
House Bill 5574 (Substitute H-2 as passed by the House)
Sponsors: Representative Sharon Gire (H.B. 5570)
Representative Laura Baird (H.B. 5571)
Representative John Jamian (H.B. 5572)
Representative Penny Crissman (H.B. 5573)
Representative Gerald Law (H.B. 5574)
House Committee: Health Policy
Senate Committee: Health Policy and Senior Citizens

Date Completed: 10-15-96

CONTENT

The bills would amend various Acts to do the following:

- **Require a health care corporation (Blue Cross and Blue Shield of Michigan), a health maintenance organization (HMO), or a health insurer by October 1, 1997, to provide to subscribers a written document "in plain English" that described the terms and conditions of the organization's certificate, contract, or policy.**
- **Require a health care corporation, HMO, or health insurer to provide a "clear, complete, and accurate description" of its provider network, specific information about participating providers, and other specified information about the organization.**
- **Require a health care corporation, HMO, or health insurer to establish by October 1, 1997, a formal grievance procedure and an expedited grievance procedure for subscribers.**
- **Specify that a health care corporation, HMO, or health insurer could under a nongroup contract exclude an individual from coverage for a preexisting condition, but for not more than six months after the effective date of the coverage; and provide that coverage for a preexisting condition for an individual could not be excluded under a group contract.**
- **Require a prudent purchaser organization or an HMO to notify health care providers in the geographic area served by it of the formation of a provider panel, including publication in a general circulation newspaper at least 30 days before an initial application period; and provide for an initial 60-day application period and a 60-day provider application period at least every four years thereafter.**
- **Allow an HMO to limit the number of contracts it entered into with health care providers, and allow all interested health professionals in an HMO service area an opportunity to apply to the HMO to become an affiliated provider.**

House Bills 5570 (H-2) and 5573 (H-2) would amend Part 210 of the Public Health Code, which governs HMOs; House Bill 5571 (H-3) would amend the Nonprofit Health Care Corporation Reform Act, which governs Blue Cross and Blue Shield of Michigan; House Bill 5572 (H-2) would amend the Insurance Code regarding insurers who sell expense-incurred hospital, medical, or surgical policies; and House Bill 5574 (H-2) would amend the Prudent Purchaser Act. House Bills 5571 (H-3), 5572 (H-2), and 5573 (H-2) would take effect October 1, 1997. Following is a detailed description of the bills.

House Bills 5571 (H-3), 5572 (H-2), and 5573 (H-2)

Each of the bills would place in law requirements regarding plain English descriptions of health care policies, contracts, or certificates; requests by enrollees for descriptions of providers and other specified information; the establishment of grievance procedures; and preexisting conditions.

Currently, under Section 21086 of the Public Health Code, upon the issuance of an HMO contract and upon written request thereafter, an HMO must give each subscriber a complete, clear, and understandable description of services to be provided. The description must include information on where and how to obtain services; a statement of the rights and responsibilities of the enrollee; information on the total or rate of payment for services; where and how emergency and out-of-area services can be obtained; a system of resolving enrollee grievances; and other information prescribed by the Department of Consumer and Industry Services (DCIS) and the Insurance Bureau. House Bill 5573 (H-2) would repeal Section 21086.

Explanation of Policies

The bills would require a health care corporation, HMO, or health insurer, by October 1, 1997, to provide to subscribers, upon enrollment, a written document in plain English that described the terms and conditions of the organization's certificate. The document would have to provide a clear, complete, and accurate description of 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 member financial responsibility for copayments, deductibles, and any other out-of-pocket expenses; provision for continuity of treatment in the event a provider's participation terminated during the course of a member's treatment by that provider; and the telephone number to call for information concerning member grievance procedures.

Requested Information

By October 1, 1997, a health care corporation or health insurer would have to provide, upon request by an enrollee for services offered under a prudent purchaser agreement (or upon request of an enrollee under an HMO contract), a clear, complete, and accurate description of any of the following information:

-- The current provider network in the service area, including names and locations of participating providers by specialty or types of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers would not accept new members.
-- The professional credentials of all participating specialists, including professional degrees relevant to the specialty; date of certification by the applicable nationally recognized boards and other professional bodies; and the names of licensed facilities where the provider had privileges for his or her specialty.
-- The Department's licensing verification telephone number for information as to whether any disciplinary actions or open formal complaints had been taken or filed against a health care provider in the immediately preceding 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.
-- Indication of the financial relationships between the health care insurer and any closed provider panel, including, as applicable, whether there was a fee-for-service arrangement under which the provider was paid a specified amount for each covered service rendered to the participant; whether there was a capitation arrangement under which a fixed amount was paid to the provider for all covered services that were or could be rendered to each covered individual or family; and whether payments to providers were made based on standards relating to cost, quality, or patient satisfaction.
-- A telephone number and address to obtain from the insurer additional information concerning the items described above.

Upon written request, any of the above information provided would have to be given in writing.

Preexisting Conditions

House Bills 5571 (H-3) and 5572 (H-2) would allow a health care corporation or health insurer,

respectively, to exclude from coverage an individual covered under a nongroup contract for a preexisting condition that required active medical treatment during the six months before enrollment; however, coverage could not be excluded for more than six months after the effective date of the health care policy. A health care corporation or an insurer could not exclude coverage for a preexisting condition for an individual covered under a group certificate. House Bill 5572 (H-2) specifies that these would apply only to an insurer that delivered, issued for delivery, or renewed in Michigan an expense-incurred hospital, medical, or surgical policy.

Currently, under the Public Health Code, an HMO may exclude coverage for a preexisting condition (under a nongroup contract) that required active medical treatment during the six months before enrollment, but for not more than six months after the effective date of the HMO contract. House Bill 5573 (H-2) would retain this provision; provide that an HMO could not exclude coverage for a preexisting condition under a group contract; and eliminate current language for the exclusion of coverage under a nongroup contract for up to nine months for maternity and obstetrical care related to a pregnancy that started before enrollment.

Grievance Procedures

Currently, under the Nonprofit Health Care Corporation Reform Act, a health care corporation must establish internal procedures for a private informal managerial-level conference to resolve a dispute between an enrollee and the corporation. House Bill 5571 (H-3) would require that the internal procedures provide that a final determination would be made in writing by the health care corporation within 90 calendar days after a grievance was submitted in writing by the enrollee or person authorized in writing to act on behalf of the enrollee. The timing for the 90-calendar-day period could be tolled (suspended), however, for any period of time the member was permitted to take under the grievance procedure.

By October 1, 1997, a health care corporation would have to establish, as part of its internal procedures, an *expedited* grievance procedure. An expedited grievance would apply if a grievance were submitted and a physician, orally or in writing, substantiated that the 90-day time frame for a grievance would acutely jeopardize the life of the member. The expedited grievance procedure would not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services. (An expedited grievance would be an oral or written statement by a member, or a person authorized in writing to act on behalf of the member, to the health care corporation that it had wrongfully refused or failed to respond in a timely manner to a request for benefits or payment.)

The expedited grievance procedure would have to provide that the health care corporation would make an initial determination within 72 hours after receiving the grievance. Within three business days after the initial determination, the member or a person authorized in writing to act on behalf of the member could request further review by the health care corporation or a determination of the matter by the Insurance Commissioner or his or her designee. If further review were requested, the health care corporation would have to make a final determination within 30 days after receiving the request for further review. Within 10 days after receiving a final determination, the member, or a person acting on his or her behalf, could request a determination of the matter by the Commissioner or his or her designee. If the initial or final determination by the health care corporation were made orally, the health care corporation would have to provide a written confirmation of the determination to the member within two business days after the oral determination.

House Bill 5572 (H-2) provides that, by October 1, 1997, an insurer would have to establish an internal formal grievance procedure for approval by the Insurance Bureau for persons covered under a health policy or certificate. The grievance procedure would not apply to a health provider's complaint concerning claims payment, handling, or reimbursement for health care services. The Insurance Commissioner would have to establish a procedure for a determination of a grievance that was 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. (A "grievance" would be a complaint on behalf of an insured person submitted by an insured person, or a person authorized in writing to act on his or her behalf, regarding the availability, delivery, or quality of health care services, including a complaint regarding an "adverse determination" made pursuant to utilization review; benefits or claims payment, handling, or reimbursement for health care services; or matters pertaining to the contractual relationship between an insured and

the insurer. An "adverse determination" would be a determination by an insurer or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service had been reviewed and, based upon the information provided, did not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service was therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination would constitute an adverse determination.)

The internal formal grievance procedure established by an insurer would have to do the following:

-- Provide for a designated person responsible for administering the grievance 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 investigation and for advisement of the insured's right to review of the grievance by the Insurance 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 had been taken.
-- Provide for copies of all complaints and responses to be available at the insurer's principal office for inspection by the Insurance Bureau for two years following the year the complaint was filed.
-- Provide that when an adverse determination was made, a written statement containing the reasons for the adverse determination would be provided to the insured person.
-- Provide that a written notification of the grievance procedures would be provided to the insured person when he or she contested an adverse determination.
-- Provide that a final determination would be made in writing by the insurer within 90 calendar days after the insured person submitted a formal grievance in writing. The timing for the 90-calendar-day period could be tolled, however, for any period of time the insured person was permitted to take under the grievance procedure.
-- Provide that the insured had the right to a determination of the matter by the Insurance Commissioner or his or her designee.

Further, the grievance procedure established by the insurer would have to provide for an expedited grievance. An expedited grievance would apply if a grievance were submitted and a physician, orally or in writing, substantiated that the 90-day time frame for a formal grievance would acutely jeopardize the life of the insured. The insurer would have to make an initial determination not later than 72 hours after receiving an expedited grievance. Within three business days after the initial determination, the insured or a person authorized in writing to act on his or her behalf could request further review by the insurer or a determination of the matter by the Commissioner or his or her designee. If further review were requested, the insurer would have to make a final determination within 30 days after receiving the request. Within 10 days after receiving a final determination, the insured or a person acting on his or her behalf, could request a determination of the matter by the Commissioner or his or her designee. If the insurer's initial or final determination were made orally, the insurer would have to provide a written confirmation of the determination to the insured within two business days after the oral determination.

Currently, under the Public Health Code, one of the conditions for licensure of an HMO is that the DCIS, with the concurrence of the Insurance Bureau, is satisfied that a "reasonable procedure exists for resolving enrollee grievances". House Bill 5573 (H-2) would require an HMO, by October 1, 1997, to establish an internal formal grievance procedure for approval by the Insurance Bureau. The requirement would not apply to a health provider's complaint concerning claims payment, handling, or reimbursement for health care services. The grievance procedure would have to include the following:

-- That when an adverse determination was made, a written statement containing the reasons for it would have to be provided to an enrollee.
-- That a written notification of the grievance procedures would have to be provided to an enrollee when he or she contested an adverse determination.

-- That the organization would have to make a final determination in writing not later than 90 calendar days after an enrollee submitted a formal grievance. The timing for the 90-calendar-day period could be tolled, however, for any period of time the enrollee was permitted to take under the grievance procedure.

The grievance procedure also would have to include provisions for an expedited grievance, in the same manner that an expedited grievance would have to be established under the Insurance Code (as proposed in House Bill 5572 (H-2)), except that an enrollee could appeal the determination of an HMO to the DCIS instead of the Insurance Commissioner.

House Bills 5570 (H-2) and 5574 (H-2)

House Bill 5570 (H-1) would include in Part 210 of the Public Health Code (which governs HMOs) provisions currently contained in the Prudent Purchaser Act regarding contracts with health professionals, by placing a limit on the number of contracts, and allowing health professionals an opportunity to apply to become an "affiliated provider". The bill would apply if an HMO contracted with health professionals for those professionals to become "affiliated providers" or offered a "prudent purchaser contract". (An "affiliated provider", under the Code, is a health professional, licensed hospital, pharmacy, or any other institution, organization, or person that has a contract with an HMO to render services to a client. A "prudent purchaser contract" is a contract offered by an HMO to groups or individuals, under which enrollees who elect to obtain health care directly from the HMO or its affiliated providers receive financial advantage or other advantage by selecting such providers.)

The bill provides that an HMO could enter into a contract with one or more health professionals to control health care costs, assure appropriate utilization of health care services, and maintain quality of health care. The HMO could limit the number of contracts entered into if the number of contracts were sufficient to assure reasonable levels of access to health care services for recipients. The number of contracts authorized that were necessary to assure reasonable levels of access to health care services would have to be determined by the HMO, as approved by the DCIS. The HMO would have to offer a contract, comparable to those contracts entered into with other affiliated providers, to at least one health professional located within a reasonable distance from the recipients of those services, if a health professional were located within reasonable distance.

An HMO would have to give all interested health professionals located in the geographic area served by the HMO an opportunity to apply to it to become an affiliated provider. The HMO would have to file a contract with the Department or Insurance Commissioner on a form and in a manner that was uniformly developed and applied by the Department or Commissioner. The contract would have to be based upon written standards for maintaining quality health care; controlling health care costs; assuring appropriate utilization of health care services; assuring reasonable levels of access to health care services; and other standards considered appropriate by the HMO. If the Department or Commissioner determined that the standards duplicated standards already filed by the HMO, the duplicative standards would not need to be filed.

Under the Prudent Purchaser Act, an organization (an insurer, dental care corporation, hospital service corporation, medical care corporation, health care corporation, or third party administrator) may enter into a prudent purchaser agreement with health care providers. Under both House Bill 5574 (H-2) and House Bill 5570 (H-2), an organization under the Prudent Purchaser Act and an HMO under the Public Health Code would have to develop and institute procedures that were designed to notify health care providers located in the geographic area served by the organization or HMO of the formation of a provider panel. The bill would require that the procedures include the giving of notice to providers of the service upon request and include publication in a newspaper with general circulation in the geographic area served by the organization, at least 30 days before the initial provider application period. An organization would have to provide for an initial 60-day provider application period during which providers of the service could apply to the organization for membership on the provider panel. An organization that had entered into a prudent purchaser agreement concerning a particular health care service would have to provide, at least once every four years, for a 60-day provider application period during which providers of that service could apply to the organization for membership on the provider panel. Notice of the provider application period would have to be given to providers of the service upon request and be published in a newspaper

with general circulation in the geographic area served by the organization at least 30 days before the commencement of the provider application period. Within 60 days after the close of the period, the organization would have to notify an applicant in writing as to whether the applicant had been accepted or rejected for membership on the provider panel. If an applicant had been rejected, the organization would have to state in writing the reasons for rejection, citing one or more of the standards.

A health care provider whose membership on an organization's provider panel was terminated would have to be provided upon request with a written explanation of the reasons for the termination.

Under House Bill 5574 (H-2), an organization that established a prudent purchaser agreement would have to disclose in writing to all purchasers of its coverage and to all covered members of its plans, upon request, the financial relationships between the organization and its participating providers, facilities, or other entities, including all of the following as applicable:

-- Whether there existed a fee-for-service arrangement, under which the provider was paid a specified fee for each particular covered service rendered to each covered individual.
-- Whether there was a capitation arrangement, under which a fixed amount was paid to the provider for all covered services rendered to each covered individual.
-- Whether payments to providers were made according to how well the provider met criteria regarding costs, quality, patient satisfaction, or other criteria.

Proposed MCL 333.21053c (H.B. 5570)
MCL 550.1404 et al. (H.B. 5571)
Proposed MCL 500.2212 et al. (H.B. 5572)
MCL 333.21073 et al. (H.B. 5573)
MCL 550.53 et al. (H.B. 5574)

Legislative Analyst: G. Towne

FISCAL IMPACT

The SFA's preliminary research* indicates that this package of bills may have significant direct and indirect cost implications on this State's health care-related expenditures.

The SFA has taken this initial position based on the belief that the sections of House Bills 5570, 5571, 5573, and 5574 dealing with the relationship between managed care organizations (MCOs) and the health care provider community would, in practice, severely curtail the ability of these organizations to negotiate and selectively contract with providers. The SFA has found that there are numerous studies showing that it is this dynamic that accounts for a major part of the observed price differential between MCOs and fee-for-service health care. If this limitation on MCOs' ability to control costs actually occurred, this State's Medicaid program, which is relying heavily on managed health care to constrain program expenditures, could lose the approximate 10% discount it currently has with managed care at a cost of over $100 million GF/GP annually.

The SFA also has found evidence that the sections of House Bills 5571 and 5572 dealing with pre-existing medical condition exclusions could very well result in an increase in individual health insurance product prices to such a level that only high income individuals would be able to afford them. In brief, unlike Medicare, Medicaid, and even employer-sponsored health insurance, which are more or less subsidized health care financing mechanisms, individual health insurance policies are primarily true "insurance" instruments. In other words, these policies are predicated on an individual's desire to forego a given amount of current income in order to protect against a large loss of future wealth resulting from an adverse event with a low probability of occurrence. If the "pool" were expanded to include coverage for known conditions, then the "average" cost of each policy would be increased. Thus, a household (especially at the lower end of the income scale) might find that the "new" price of the policy exceeded the expected cost of a low probability event. This would result in some individuals' dropping their coverage. As the insured "pool" proportionately covered more persons with a high probability of large expenditures, the average price of this policy again would increase and the cycle would be repeated. The bottom line is that eventually the policy price would be so high that this product line is no longer marketable.

In that event, the State could very well find itself with an increasing number of uninsured people. While the probability of untoward events is low, some of these persons eventually would require health care services that they could not afford. Their fall-back position would be to use the State's

Medicaid program. While the number of persons who would end up following this path is hard to quantify, it should be noted that somewhere over 6% of the nonelderly persons in this State are covered by individual policies. That is over 500,000 individuals and it is not hard to see how even a small percentage of those persons having large medical bills would significantly affect the State Medicaid program.

The sections of these bills regarding grievance procedures are expected to have a nominal impact on State spending as the Insurance Commission already handles such grievances.

*The Agency is in the process of producing a detailed paper on these fiscal issues, which should be available by the next committee hearing.

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