Act No. 516
Public Acts of 1996
Approved by the Governor
January 12, 1997
Filed with the Secretary of State
January 13, 1997

STATE OF MICHIGAN
88TH LEGISLATURE
REGULAR SESSION OF 1996

Introduced by Reps. Baird, Schroer, Freeman, Profit, Rocca, Griffin, Anthony, Gire, Gubow, Brater, Cherry, Berman, Horton, Dolan, Kukuk, Jamian, Jellema, Goschka, Crissman, Hill, Harder, Walberg, Gernaat, Gustafson, Curtis, DeHart, Pitoniak, Yokich, Baade, Weeks, LeTarte, Green, Rhead, McManus, Fitzgerald, Alley, Bankes, Lowe, Galloway, Middleton, Bodem, Llewellyn, Wetters and Hertel

Reps. Agee, Bennane, Brackenridge, Brewer, Bush, Byl, Ciaramitaro, Clack, Cropsey, Dalman, DeLange, DeMars, Dobb, Dobronski, Emerson, Gagliardi, Geiger, Gilmer, Gnodtke, Hammerstrom, Hanley, Jersevic, Kelly, Kilpatrick, LaForge, London, Martinez, Mathieu, McBryde, McNutt, Middaugh, Murphy, Nye, Olshove, Owen, Oxender, Palamara, Parks, Perricone, Porreca, Price, Prusi, Randall, Ryan, Scott, Sikkema, Tesanovich, Varga, Vaughn, Voorhees, Wallace, Whyman and Willard named co-sponsors

ENROLLED HOUSE BILL No. 5571

AN ACT to amend section 404 of Act No. 350 of the Public Acts of 1980, entitled as amended "An act to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for a Michigan caring program; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to provide for the imposition of a regulatory fee; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal certain acts and parts of acts," being section 550.1404 of the Michigan Compiled Laws; and to add sections 401e, 402a, and 402b.

The People of the State of Michigan enact:

Section 1. Section 404 of Act No. 350 of the Public Acts of 1980, being section 550.1404 of the Michigan Compiled Laws, is amended and sections 401e, 402a, and 402b are added to read as follows:

Sec. 401e. (1) Except as provided in this section, a health care corporation that has issued a nongroup certificate shall renew or continue in force the certificate at the option of the individual.

(2) Except as provided in this section, a health care corporation that has issued a group certificate shall renew or continue in force the certificate at the option of the sponsor of the plan.

(3) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health care corporation no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

Sec. 402a. (1) By October 1, 1997, a health care corporation shall provide a written form in plain English to subscribers upon enrollment that describes the terms and conditions of the corporation's certificate. The form shall provide a clear, complete, and accurate description of all of the following as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of member financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment in the event a provider's participation terminates during the course of a member's treatment by that provider.

(g) The telephone number to call to receive information concerning member grievance procedures.

(h) A summary listing of the information available pursuant to subsection (2).

(2) By October 1, 1997, a health care corporation shall provide upon request to members for services offered pursuant to section 502a a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the certificate's 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 providers will not accept new members.

(b) The professional credentials of participating health professionals, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the health professional presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the Michigan department of consumer and industry services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.

(d) 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.

(e) Indication of the financial relationships between the health care corporation and any closed provider panel including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the health care corporation additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) shall be provided in writing. A health care corporation may require that a request under subsection (2) be submitted in writing.

Sec. 402b. (1) For an individual covered under a nongroup certificate or under a certificate not covered under subsection (2), a health care corporation may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the certificate.

(2) A health care corporation shall not exclude or limit coverage for a preexisting condition for an individual covered under a group certificate.

(3) The commissioner and the director of community health shall examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by a preexisting condition limitation or exclusion under subsection (1) and shall report to the governor and the senate and the house of representatives standing committees on insurance and health policy issues by May 15, 1997. The report shall include the commissioner's and director's findings and shall propose alternative mechanisms or a combination of mechanisms to credit prior continuous health care coverage towards the period of time imposed by a preexisting condition limitation or exclusion. The report shall address at a minimum all of the following:

(a) Cost of crediting prior continuous health care coverages.

(b) Period of lapse or break in coverage, if any, permitted in a prior health care coverage.

(c) Types and scope of prior health care coverages that are permitted to be credited.

(d) Any exceptions or exclusions to crediting prior health care coverage.

(e) Uniform method of certifying periods of prior creditable coverage.

(4) As used in this section, "group" means a group of 2 or more subscribers.

Sec. 404. (1) A person who has reason to believe that a health care corporation has violated section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, is entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner or his or her designee if the conference fails to resolve the dispute.

(2) A health care corporation shall establish reasonable internal procedures to provide a person with a private informal managerial-level conference as provided in subsection (1). This procedure shall provide that a final determination will be made in writing by the health care corporation not later than 90 calendar days after a grievance is submitted in writing by the member or person, including, but not limited to, a physician, authorized in writing to act on behalf of the member. The timing for the 90-calendar-day period may be tolled, however, for any period of time the member is permitted to take under the grievance procedure. These procedures shall include all of the following:

(a) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of a certificate or to the rate charged.

(b) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.

(3) If the health care corporation fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the corporation after completion of the conference, the person is entitled to a determination of the matter by the commissioner or his or her designee.

(4) By October 1, 1997, a health care corporation shall establish, as part of its internal procedures, an expedited grievance procedure. The expedited grievance procedure shall provide that an initial determination will be made by the health care corporation not later than 72 hours after receipt of the grievance. Within 3 business days after the initial determination by the health care corporation, the member or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the member may request further review by the health care corporation or for a determination of the matter by the commissioner or his or her designee under this section. If further review is requested, a final determination by the health care corporation shall be made not later than 30 days after receipt of the request for further review. Within 10 days after receipt of a final determination, the member or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the member may request a determination of the matter by the commissioner or his or her designee under this section. If the initial or final determination by the health care corporation is made orally, the health care corporation shall provide a written confirmation of the determination to the member not later than 2 business days after the oral determination. An expedited grievance under this subsection applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subsections (1) to (3) would acutely jeopardize the life of the member. This subsection does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services. As used in this subsection, "grievance" means an oral or written statement, by a member or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the member, to the health care corporation that the health care corporation has wrongfully refused or failed to respond in a timely manner to a request for benefits or payment.

(5) The commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

(6) If either the health care corporation or the person disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

Section 2. This amendatory act shall take effect October 1, 1997.

This act is ordered to take immediate effect.

Clerk of the House of Representatives.

Secretary of the Senate.

Approved _____

Governor.