HOUSE BILL No. 5571

February 13, 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 and referred to the Committee on Health Policy.

A bill to amend Act No. 350 of the Public Acts of 1980, entitled as amended

"The nonprofit health care corporation reform act,"

as amended, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, by adding sections 402a, 402b, 409a, 501b, and 501c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Act No. 350 of the Public Acts of 1980, as amended, being sections 550.1101 to 550.1704 of the Michigan Compiled Laws, is amended by adding sections 402a, 402b, 409a, 501b, and 501c to read as follows:

SEC. 402A. (1) BY OCTOBER 1, 1996, THE COMMISSIONER SHALL PROVIDE TO HEALTH CARE CORPORATIONS A STANDARD WRITTEN FORM THAT HEALTH CARE CORPORATIONS SHALL USE TO DESCRIBE THE TERMS AND CONDITIONS OF THE CORPORATION'S CERTIFICATE. THE FORM SHALL BE

IN PLAIN ENGLISH AND SHALL BE DESIGNED SO THAT INDIVIDUALS CAN EASILY MAKE COMPARISONS AND INFORMED DECISIONS BEFORE SELECTING AMONG HEALTH CARE PLANS. THE FORM SHALL REQUIRE THE CORPORATION TO PROVIDE A CLEAR, COMPLETE, AND ACCURATE DESCRIPTION OF ALL OF THE FOLLOWING AS APPLICABLE:

(A) THE CURRENT PROVIDER NETWORK, INCLUDING NAMES AND LOCATIONS OF PARTICIPATING PROVIDERS BY MEDICAL SPECIALTY OR TYPE OF PRACTICE, IN THE INDIVIDUAL'S LOCALE, A STATEMENT OF LIMITATIONS OF ACCESSIBILITY AND REFERRALS TO SPECIALISTS, AND A DISCLOSURE OF WHICH PROVIDERS WILL NOT ACCEPT NEW SUBSCRIBERS OR PARTICIPATE IN CLOSED PROVIDER NETWORKS SERVING ONLY CERTAIN SUBSCRIBERS.

(B) THE PROFESSIONAL CREDENTIALS OF ALL PARTICIPATING SPECIALISTS, INCLUDING TYPE OF BOARD CERTIFICATION AND TYPE OF SPECIALIZATION; EXTENT OF EXPERIENCE, INCLUDING YEARS IN PRACTICE, TYPE OF PRACTICE, AND FACILITIES IN WHICH THE PROVIDER HAS PRACTICED, IF APPLICABLE; NATURE AND TYPE OF TRAINING THAT THE PROVIDER HAS COMPLETED; EXTRAORDINARY TRAINING; PARTICULAR EXPERTISE WITHIN A PROVIDER SPECIALTY; DISCIPLINARY ACTIONS THAT HAVE BEEN TAKEN AGAINST THE PROVIDER; LIMITATIONS OR RESTRICTIONS THAT HAVE BEEN PLACED ON THE PROVIDER'S PRACTICE; AND LENGTH OF TIME AS A PARTICIPATING PROVIDER.

(C) THE SERVICE AREA.

(D) COVERED BENEFITS, INCLUDING PRESCRIPTION DRUG COVERAGE, WITH SPECIFICATIONS REGARDING REQUIREMENTS FOR THE USE OF GENERIC DRUGS.

(E) EMERGENCY HEALTH COVERAGES AND BENEFITS.

(F) OUT-OF-AREA COVERAGES AND BENEFITS.

(G) ANY LIMITATIONS, RESTRICTIONS, EXCLUSIONS, OR PRIOR AUTHORIZATION REQUIREMENTS 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.

(H) AN EXPLANATION OF SUBSCRIBER FINANCIAL RESPONSIBILITY FOR COPAYMENTS, DEDUCTIBLES, AND ANY OTHER OUT-OF-POCKET EXPENSES FOR NONCOVERED SERVICES OR FOR SERVICES RECEIVED FROM A NONPARTICIPATING PROVIDER.

(I) PROVISION FOR CONTINUITY OF TREATMENT IN THE EVENT OF THE TERMINATION OF PARTICIPATION BY A PRIMARY CARE OR SPECIALIST PHYSICIAN WHOSE PARTICIPATION IS TERMINATED DURING THE COURSE OF A SUBSCRIBER'S TREATMENT BY THAT SPECIALIST.

(J) ANY PRIOR AUTHORIZATION REQUIREMENT, INCLUDING PROCEDURES FOR AND LIMITATIONS OR RESTRICTIONS ON REFERRALS TO PROVIDERS OTHER THAN PRIMARY CARE PHYSICIANS, OR OTHER REVIEW REQUIREMENTS, INCLUDING PRIOR AUTHORIZATION REVIEW, CONCURRENT REVIEW, POSTSERVICE REVIEW, AND POSTPAYMENT REVIEW, AND THE CONSEQUENCES OF FAILING TO OBTAIN ANY REQUIRED AUTHORIZATIONS.

(K) THE SIGNIFICANT GENERAL TERMS OF THE FINANCIAL RELATIONSHIPS BETWEEN THE HEALTH CARE CORPORATION AND ITS PARTICIPATING PROVIDERS, FACILITIES, OR OTHER ENTITIES, INCLUDING ANY AGREEMENTS OR ARRANGEMENTS OR OWNERSHIP RELATIONSHIPS.

(*l*) A TELEPHONE NUMBER AND ADDRESS FOR THE PROSPECTIVE SUBSCRIBER TO OBTAIN ADDITIONAL INFORMATION CONCERNING THE TIMES DESCRIBED IN SUBDIVISIONS (A) TO (K).

(2) BEGINNING JANUARY 1, 1997, A HEALTH CARE CORPORATION SHALL PROVIDE TO PROSPECTIVE SUBSCRIBERS AND FILE ANNUALLY WITH THE COMMISSIONER A COMPLETED COPY OF THE WRITTEN DESCRIPTION DESCRIBED IN SUBSECTION (1).

SEC. 402B. FOR AN INDIVIDUAL COVERED UNDER A NONGROUP CONTRACT, A HEALTH CARE CORPORATION MAY EXCLUDE COVERAGE FOR A PREEXISTING CONDITION THAT REQUIRED ACTIVE MEDICAL TREATMENT DURING 6 MONTHS BEFORE ENROLLMENT BUT COVERAGE SHALL NOT BE EXCLUDED FOR MORE THAN 6 MONTHS AFTER THE EFFECTIVE DATE OF THE HEALTH CARE CORPORATION CERTIFICATE. EXCEPT AS OTHERWISE PROVIDED FOR MATERNITY CARE AND OBSTETRICAL SERVICE, A HEALTH CARE CORPORATION SHALL NOT EXCLUDE COVERAGE FOR A PREEXISTING CONDITION FOR AN INDIVIDUAL COVERED UNDER A GROUP CERTIFICATE. COVERAGE UNDER A NONGROUP OR GROUP CERTIFICATE FOR MATERNITY CARE AND OBSTETRICAL SERVICE RELATED TO A PREGNANCY THAT STARTED BEFORE ENROLLMENT MAY BE EXCLUDED FOR UP TO 9 MONTHS.

SEC. 409A. NOTWITHSTANDING SECTION 409, A HEALTH CARE CORPORATION THAT, AGAINST THE ADVICE AND JUDGMENT OF THE TREATING PHYSICIAN, LIMITS OR RESTRICTS A COVERED SERVICE OR A COURSE OF TREATMENT THAT FALLS WITHIN ITS CERTIFICATE BENEFITS OR COVERAGES AND EITHER ALTERS THE COURSE OF MEDICAL TREATMENT OR DENIES ACCESS TO SERVICES OR CONTINUED TREATMENT SHALL INDEMNIFY ANY TREATING HEALTH CARE PROVIDERS WHO SUBSEQUENTLY BECOME LIABLE TO THE SUBSCRIBER FOR DAMAGES CAUSED BY THE LIMITATION OR RESTRICTION FOR THE FULL EXTENT OF EACH PROVIDER'S LIABILITY FOR MONETARY DAMAGES.

SEC. 501B. A HEALTH CARE CORPORATION SHALL NOT DENY REIMBURSEMENT OR PARTICIPATION TO A LICENSED NATIONALLY ACCREDITED, FREESTANDING AMBULATORY SURGICAL FACILITY FOR A LICENSED COVERED SERVICE.

SEC. 501C. A HEALTH CARE CORPORATION SHALL NOT USE FINANCIAL INCENTIVES TO ENCOURAGE A HEALTH CARE PROVIDER TO REFER A SUBSCRIBER TO ANOTHER HEALTH CARE PROVIDER AND SHALL NOT USE FINANCIAL INCENTIVES TO DISCOURAGE A HEALTH CARE PROVIDER FROM REFERRING A SUBSCRIBER TO ANOTHER HEALTH CARE PROVIDER.