HOUSE BILL No. 5572

February 13, 1996, Introduced by Reps. Jamian, Gubow, Horton, Profit, Hill, Dolan, Rocca, Kukuk, Baird, Jellema, Goschka, Crissman, Freeman, Harder, Gire, Curtis, DeHart, Pitoniak, Yokich, Weeks, LeTarte, Hertel, Baade, Green, Rhead, McManus, Fitzgerald, Alley, Schroer, Bankes, Cherry, Middleton, Gustafson, Lowe, Wetters, Galloway, Brater, Walberg, Bodem, Llewellyn and Gernaat and referred to the Committee on Health Policy.

A bill to amend Act No. 218 of the Public Acts of 1956, entitled as amended

"The insurance code of 1956,"

as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws, by adding sections 2212, 2213, and 3406f.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws, is amended by adding sections 2212, 2213, and 3406f to read as follows:

SEC. 2212. (1) BY OCTOBER 1, 1996, THE COMMISSIONER SHALL PROVIDE TO INSURERS THAT DELIVER, ISSUE FOR DELIVERY, OR RENEW IN THIS STATE AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY OR CERTIFICATE A STANDARD WRITTEN FORM THAT INSURERS SHALL USE TO DESCRIBE THE TERMS AND CONDITIONS OF THE INSURERS'

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

(A) IF APPLICABLE, THE CURRENT PROVIDER NETWORK, INCLUDING NAMES AND LOCATIONS OF PROVIDERS, A STATEMENT OF LIMITATIONS OF ACCESSIBILITY AND REFERRALS TO SPECIALISTS, AND A DISCLOSURE OF WHICH PROVIDERS WILL NOT ACCEPT NEW INSUREDS OR PARTICIPATE IN CLOSED PROVIDER NETWORKS SERVING ONLY CERTAIN INSUREDS.

(B) THE PROFESSIONAL CREDENTIALS OF ALL SPECIALISTS WHO ARE INCLUDED IN ANY CLOSED PANEL PLANS, 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 CLOSED-PANEL PROVIDER.

(C) ANY APPLICABLE SERVICE AREA LIMITATIONS.

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

(E) EMERGENCY CARE COVERAGE.

(F) IF APPLICABLE, 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 THE INSURED'S FINANCIAL RESPONSIBILITY FOR COPAYMENTS, DEDUCTIBLES, AND ANY OTHER OUT-OF-POCKET EXPENSES.

(I) IF APPLICABLE, PROVISION FOR CONTINUITY OF TREATMENT IN THE EVENT OF THE TERMINATION OF A PHYSICIAN FROM PARTICIPATION IN A CLOSED PANEL.

(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 INSURER AND ANY PROVIDER OR PROVIDER GROUP, FACILITY, OR OTHER ENTITY, INCLUDING ANY AGREEMENTS OR ARRANGEMENTS OR OWNERSHIP RELATIONSHIPS.

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

(2) BEGINNING JANUARY 1, 1997, AN INSURER SHALL PROVIDE TO PROSPECTIVE INSUREDS AND FILE ANNUALLY WITH THE COMMISSIONER A

COMPLETED COPY OF THE WRITTEN DESCRIPTION DESCRIBED IN SUBSECTION (1).

SEC. 2213. AN INSURER 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 POLICY OR 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 INSURED FOR DAMAGES CAUSED BY THE LIMITATION OR RESTRICTION FOR THE FULL EXTENT OF EACH PROVIDER'S LIABILITY FOR MONETARY DAMAGES.

SEC. 3406F. (1) FOR AN INDIVIDUAL COVERED UNDER AN INDIVIDUAL POLICY, AN INSURER 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 POLICY. EXCEPT AS OTHERWISE PROVIDED FOR MATERNITY CARE AND OBSTETRICAL SERVICE, AN INSURER SHALL NOT EXCLUDE COVERAGE FOR A PREEXISTING CONDITION FOR AN INDIVIDUAL COVERED UNDER A GROUP CERTIFICATE. COVERAGE UNDER AN INDIVIDUAL OR GROUP POLICY OR CERTIFICATE FOR MATERNITY CARE AND OBSTETRICAL SERVICE RELATED TO A PREGNANCY THAT STARTED BEFORE ENROLLMENT MAY BE EXCLUDED FOR UP TO 9 MONTHS.

(2) THIS SECTION APPLIES ONLY TO AN INSURER THAT DELIVERS, ISSUES FOR DELIVERY, OR RENEWS IN THIS STATE AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL POLICY OR CERTIFICATE.