House
Legislative
Analysis
Section

Romney Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

EXPERIMENTAL THERAPY DISPUTES

House Bills 5571-5574
Sponsor: Rep. Mary Schroer
Committee: Insurance

Complete to 3-20-98

A SUMMARY OF HOUSE BILLS 5571-5574 AS INTRODUCED 2-12-98

House Bill 5571 would create the Experimental Treatment Dispute Resolution Act, under which a covered person could appeal to an independent panel of experts the decision of a health care plan to deny coverage for an experimental or non-standard treatment or therapy. Such panels would be appointed by the Experimental Treatment Dispute Resolution Commission, which would be created by the bill. The commission's members would be appointed by the governor with the advice and consent of the Senate and housed within the Department of Consumer and Industry Services.

If the majority of experts on a panel recommended providing the proposed therapy, the recommendation would be binding on the health care plan and the plan would have to provide coverage for the proposed therapy. If the recommendations of the experts were evenly divided, then the panel's decision would be in favor of coverage. If less than a majority on the panel recommended providing the therapy, the plan would not be required to provide the therapy. Coverage for services required by the bill would be provided subject to the terms and conditions generally applicable to other benefits under the plan contract.

House Bills 5572-5574 would amend three health insurance-related acts to require health plans to notify enrollees of the availability of an outside, independent review when coverage for experimental or investigational therapy was denied. The notice would have to include a description of the process, the address of the experimental treatment dispute resolution commission, and the information the enrollee must provide to the commission. The enrollee would have to notify the plan if he or she wished to request a review. House Bill 5572 would amend the Insurance Code (MCL 500.2213) to apply to commercial insurance companies. House Bill 5573 would amend the Public Health Code (MCL 333.21035) to apply to health maintenance organizations (HMOs). House Bill 5574 would amend the Nonprofit Health Care Corporation Act (MCL 550.1404). The four bills are tie-barred to one another.

Who Could Appeal. An enrollee or a person authorized in writing to act on behalf on an enrollee could request the appointment of a review panel. A panel would be appointed for an enrollee who met the following criteria.

-- The enrollee had, according to the diagnosis of the enrollee's current physician, either 1) a terminal condition with a high probability of causing death within two years; or 2) a chronic condition that reoccurred frequently and was of a duration of more than six months.

-- The enrollee's physician certified that the enrollee had a condition for which standard therapies had not been effective, or for which standard therapies would not be medically appropriate, or for which there was no therapy more beneficial covered by the plan than the non-standard therapy.

-- Either 1) the enrollee's physician who was under contract with or employed by the health plan had recommended a drug, device, procedure, or other therapy that he or she had certified in writing was more likely to be beneficial than any available standard therapy, or 2) the enrollee or the enrollee's physician who was a licensed, board-certified or board-eligible physician qualified to treat the enrollee's condition had requested a therapy that, based on two or more medical and scientific evidence documents, was likely to be more beneficial than any standard therapy. The physician certification would have to include a statement of the evidence relied on by the physician. The bill would specify that nothing in the provision would require a plan to pay for the services of a nonparticipating physician that were not otherwise covered under the plan. (The bill contains a definition of the term "medical and scientific evidence" specifying the studies, literature, and research that qualify.)

-- The enrollee had been denied coverage by the plan for a recommended drug, device, procedure, or other therapy that would have been a covered service except for the plan's determination that therapy was experimental or investigational.

The Appointment of a Panel. Within five business days of a request for the appointment of a panel, the health plan involved would have to provide to the commission copies of 1) the medical records relevant to the enrollee's condition in the plan's possession; 2) relevant documents used in determining whether the proposed therapy should be covered and any statement explaining the reasons for the plan's decision not to provide coverage; and 3) information submitted to the plan by the enrollee or the enrollee's physician in support of the request for coverage. The confidentiality of medical records would have to be maintained under confidentiality requirements recognized or created by law. The health plan would have to provide, upon request, a copy of the documents used in making its decision to the enrollee and enrollee's physician (except for medical records and statements submitted by the enrollee or enrollee's physician).

If the commission determined the necessary requirements were met, an independent panel would be selected, composed of at least three physicians or other providers who were experts in the treatment of the enrollee's medical condition and knowledgeable about the recommended therapy. Neither the plan nor the enrollee could choose or control the choice of the experts. The commission would have to ensure that no member of the panel had any material professional, familial, or financial affiliation with: the plan; any officer, director, or management employee of the plan; the physician, the physician's medical group, or the independent practice association proposing the therapy; the institution at which the therapy would be provided; the enrollee whose condition and treatment were under review; or the development or manufacture of the principal drug, service, procedure, or other therapy proposed. (The bill contains definitions of "material familial affiliation," "material financial affiliation," and "material professional affiliation.")

The Panel's Decision. The panel of experts would be required to render their analyses and recommendations within 30 days of their appointment or within 7 days if the enrollee's physician determined that the proposed therapy would be significantly less effective if not promptly initiated. Each expert's analysis and recommendation would have to be in written form and state the reasons the requested therapy was or was not likely to be more beneficial for the enrollee than any available standard therapy and the reasons that the expert recommended that the therapy should or should not be provided. The experts would have to provide the plan and the enrollee's physician with their analyses and recommendations, a description of their qualifications, and any other information they chose. As mentioned above, if a majority of the panel recommended providing the proposed therapy, the recommendation would be binding on the health plan. If the experts were divided, the panel's decision would be in favor of coverage. If less than a majority of the experts recommended providing therapy, the plan would not be required to provide it.

The Commission. The experimental treatment dispute resolution commission would consist of four representatives from the general public and one representative from each of the following: the health insurance industry; health maintenance organizations (HMOs); nonprofit health care corporations (Blue Cross and Blue Shield); the University of Michigan Medical School; the Wayne State University School of Medicine; the Michigan State College of Osteopathic Medicine or College of Human Medicine; the Michigan Health and Hospital Association; the Michigan Nurses Association; and the Michigan State Medical Society. The director of the Department of Community Health and the insurance commissioner would be ex officio members without vote.

Members would be appointed by the governor with the advice and consent of the Senate to three-year terms. (Initial terms, however, would be staggered.) A member could be removed by the governor for incompetency, dereliction of duty, malfeasance, misfeasance, or nonfeasance in office, or any other good cause. The first meeting would have to be held within 60 days after the bill's effective date and subsequent meetings would have to be held at least quarterly. The commission's performance of business would be subject to the Open Meetings Act, except for any meeting or portion of a meeting on an individual enrollee's appeal. The commission also would be subject to the Freedom of Information Act, except for information as to an individual enrollee's appeal.

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.