

Act No. 24
Public Acts of 1998
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STATE OF MICHIGAN
89TH LEGISLATURE
REGULAR SESSION OF 1998

Introduced by Senators Geake and Conroy

ENROLLED SENATE BILL No. 358

AN ACT to amend 1980 PA 350, entitled "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," by amending sections 211a, 410, and 502 (MCL 550.1211a, 550.1410, and 550.1502), section 211a as added by 1993 PA 127 and section 502 as amended by 1997 PA 184.

The People of the State of Michigan enact:

Sec. 211a. (1) As used in this section:

(a) "Noninsured benefit plan" means a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer or the portion of a health benefit plan without coverage by a health care corporation, health maintenance organization, or insurer that has a specific or aggregate excess loss coverage.

(b) "Process a claim" means the services performed in connection with a claim for benefits including the disbursement of benefit amounts.

(2) A health care corporation providing services under section 211 shall not do any of the following:

(a) Misrepresent pertinent facts relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim for benefits.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim for benefits.

(d) Refuse to process claims without conducting a reasonable investigation based upon the available information.

(e) Fail to communicate affirmation or denial of coverage of a claim for benefits within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to promptly, fairly, and equitably process a claim for benefits.

(g) Knowingly compel covered individuals to institute litigation to recover amounts due under a benefit plan or certificate by offering substantially less than the amounts due.

(h) For the purpose of coercing a covered individual to accept a settlement or compromise in a claim, inform the covered individual of a corporation policy of appealing administrative hearing decisions that are in favor of covered individuals.

(i) Delay the investigation or processing of a claim by requiring a covered individual, or the provider of services to the covered individual, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(j) Fail to promptly provide a reasonable explanation of the basis for denial or partial denial of a claim for benefits.

(k) Fail to promptly process a claim where liability has become reasonably clear under 1 portion of a benefit plan or certificate in order to influence a settlement under another portion of the benefit plan or certificate.

(l) Refuse to enter into a service contract, or refuse to provide services under a service contract because of race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(3) A corporation providing services under section 211 in connection with a noninsured benefit plan shall not, in order to induce a person to contract or to continue to contract with the corporation for the provision of services under a service contract or certificate offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate or service contract issued by the corporation; or to induce a person to secure or terminate coverage with an insurer, health care corporation, health maintenance organization, or other person, directly or indirectly, do any of the following:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a service contract or certificate other than as plainly expressed in the service contract or certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or adjustment of the rate payable on the service contract or certificate, or an advantage in the services thereunder, except as reflected in the rate and expressly provided in the service contract or certificate. Readjustment of the rate for services provided under the service contract or certificate may be made at the end of a contract or certificate year or contract or certificate period and may be made retroactive.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, an estimate, illustration, circular, or statement misrepresenting the terms of a service contract or certificate, the advantages provided thereunder, or the true nature thereof.

(e) Make a misrepresentation or incomplete comparison, whether oral or written, between service contracts or certificates of the corporation or between service contracts or certificates of the corporation and an insurer, hospital service corporation, health maintenance organization, or other person.

(4) A corporation providing services under section 211 in connection with a noninsured benefit plan shall process claims for benefits on a timely basis. If not paid on a timely basis, benefits payable to a covered individual shall bear simple interest from a date 60 days after a satisfactory claim form was received by the corporation, at a rate of 12% interest per annum. The interest shall be paid by the noninsured benefit plan in addition to, and at the time of payment of, the claim.

(5) A corporation providing services under section 211 in connection with a noninsured benefit plan shall specify in writing the materials that constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation.

(6) A corporation providing services under section 211 in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual as to what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(7) If the commissioner has probable cause to believe that a corporation is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a corporation is violating, or has violated any other subsection of this section, he or she shall give written notice to the corporation, pursuant to the administrative procedures act, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the insurance bureau responsible for the matters that would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(8) A hearing held pursuant to subsection (7) shall be held pursuant to the administrative procedures act. If, after the hearing, the commissioner determines that the corporation is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has violated or is violating any other subsection of this section, the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. In addition to a cease and desist order, the commissioner may order any of the following:

(a) Payment of a monetary penalty of not more than \$500.00 for each violation but not to exceed an aggregate penalty of \$5,000.00, unless the corporation knew or reasonably should have known it was in violation of this section, in which case the penalty shall not be more than \$2,500.00 for each violation and shall not exceed an aggregate penalty of \$25,000.00 for all violations committed in a 6-month period.

(b) Suspension or revocation of the corporation's license or certificate of authority if the corporation knowingly and persistently violated this section.

(c) Refund of any overcharges.

(9) A corporation that violates a cease and desist order of the commissioner issued under subsection (8), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than \$10,000.00 for each violation.

(10) In addition to other remedies provided by law, an aggrieved covered individual may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the covered individual shall be awarded actual monetary damages or \$200.00, whichever is greater. If the corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery shall be limited to actual monetary damages.

(11) The filing of a petition for review does not stay enforcement of action pursuant to this section, but the commissioner may grant, or the appropriate court may order, a stay upon appropriate terms.

(12) The commissioner may at any time, by order, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this section, when in his or her opinion conditions of fact or of law have so changed as to require that action or if the public interest shall so require.

Sec. 410. Any certificate issued by a health care corporation which provides that coverage of a dependent of the subscriber terminates at a specified age shall not terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical disability, if the following conditions are met:

(a) The child became incapable before 19 years of age and is chiefly dependent upon the subscriber for support and maintenance.

(b) Before the child turns 19 years of age, or within 31 days thereafter, the subscriber has submitted proof of the dependent's incapacity to the corporation.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services that the professional health care providers may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies to the health care corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

(b) That the provider will accept payment from the corporation as payment in full for all cases involving the procedure specified, for the duration of the calendar year. As used in this subdivision, provider does not include a person licensed as a dentist under part 166 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648.

(c) That the provider will not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into pursuant to subsection (1) shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which it has contracted prior to August 27, 1985 and that continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection does not apply to

limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, or to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services that are overutilized, including those services rendered, ordered, or prescribed to an extent that is greater than reasonably necessary.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation, which can be publicly displayed, to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section does not impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section shall be subject to the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding medical or surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities, is licensed under part 208 of the public health code, 1978 PA 368, MCL 333.20801 to 333.20821, and complies with part 222 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260.

(9) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

This act is ordered to take immediate effect.



Secretary of the Senate.



Clerk of the House of Representatives.

Approved _____

Governor.