

Act No. 621
Public Acts of 2002
Approved by the Governor
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**STATE OF MICHIGAN
91ST LEGISLATURE
REGULAR SESSION OF 2002**

Introduced by Rep. Bisbee

ENROLLED HOUSE BILL No. 6327

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to provide for assessment fees on certain health maintenance organizations; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending sections 224b, 2409, 2409a, 2409c, 3515, 3519, and 3528 (MCL 500.224b, 500.2409, 500.2409a, 500.2409c, 500.3515, 500.3519, and 500.3528), section 224b as added and sections 3515 and 3519 as amended by 2002 PA 304, sections 2409 and 2409a as amended by 1993 PA 200, section 2409c as added by 1986 PA 318, and section 3528 as added by 2000 PA 252.

The People of the State of Michigan enact:

Sec. 224b. (1) The department of community health shall assess on each health maintenance organization that has a medicaid managed care contract awarded by the state and administered by the department of community health a quality assurance assessment fee that equals 6% of non-medicare premiums collected by that health maintenance organization.

(2) The quality assurance assessment fee collected under subsection (1) and all federal matching funds attributed to that fee shall be used for the following purposes and under the following specific circumstances:

(a) The quality assurance assessment fee shall be implemented on May 10, 2002.

(b) The quality assurance assessment fee shall be assessed on the non-medicare premiums collected by each health maintenance organization described in subsection (1) based on the health maintenance organization's most recent statement filed with the commissioner pursuant to sections 438 and 438a. Except as otherwise provided, the quality assurance assessment fee shall be payable on a quarterly basis with the first payment due 90 days after the date the fee is assessed. If a health maintenance organization does not have non-medicare premium revenue listed in a filing under section 438 or 438a, the assessment shall be based on an estimate by the department of community health of the health maintenance organization's non-medicare premiums for the quarter and shall be payable upon receipt.

(c) The quality assurance assessment fee shall only be assessed on a health maintenance organization that has in effect a medicaid managed care contract awarded by the state and administered by the department of community health at the time of the assessment.

(d) Beginning October 1, 2007, the quality assurance assessment fee shall no longer be assessed or collected.

(e) The department of community health shall implement this section in a manner that complies with federal requirements. If the department of community health is unable to comply with the federal requirements for federal matching funds under this section or is unable to use the fiscal year 2001-2002 level of support for federal matching dollars other than for a change in covered benefits or covered population required under the state's medicaid contract with health maintenance organizations, the quality assurance assessment fee under this section shall no longer be assessed or collected.

(f) If a health maintenance organization fails to pay the quality assurance assessment fee required under subsection (1), the department of community health may assess the health maintenance organization a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department of community health may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(g) The medicaid health maintenance organization quality assurance assessment fund is established as a separate fund in the state treasury. The department of community health shall deposit the revenue raised through the quality assurance assessment fee with the state treasurer for deposit in the medicaid health maintenance organization quality assurance assessment fund.

(h) In all fiscal years governed by this section, medicaid reimbursement rates shall not be reduced below the medicaid payment rates in effect on April 1, 2002 as a direct result of the quality assurance assessment fee assessed under this section. This subdivision does not apply to a change in medicaid reimbursement rates caused by a change in covered benefits or change in covered populations required under the state's medicaid contract with health maintenance organizations.

(i) The amounts listed in this subdivision are appropriated for the department of community health, subject to the conditions set forth in this section, for the fiscal year ending September 30, 2003:

MEDICAL SERVICES

Health plan services.....	\$	1,476,781,100
Gross appropriation.....	\$	1,476,781,100
Appropriated from:		
Federal revenues:		
Total federal revenues		817,495,900
Special revenue funds:		
Medicaid quality assurance assessment.....		55,747,000
State general fund/general purpose	\$	603,538,200

(3) As used in this section:

(a) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396r-6 and 1396r-8 to 1396v.

(b) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395b-6 to 1395b-7, 1395c to 1395i, 1395i-2 to 1395i-5, 1395j to 1395t, 1395u to 1395w, 1395w-2 to 1395w-4, 1395w-21 to 1395w-28, 1395x to 1395yy, and 1395bbb to 1395ggg.

Sec. 2409. (1) By May 15, 2003 and by May 15 annually thereafter, the commissioner shall make a determination as to whether a reasonable degree of competition in the worker's compensation insurance market exists on a statewide basis. If the commissioner determines that a reasonable degree of competition in the worker's compensation insurance market does not exist on a statewide basis, the commissioner shall hold a public hearing and shall issue a report delineating specific classifications and kinds or types of insurance, if any, where competition does not exist. The report shall be based on relevant economic tests, including but not limited to those in subsection (3). The findings in the report shall not be based on any single measure of competition, but appropriate weight shall be given to all measures of competition. Any person who disagrees with the report and findings of the commissioner may request a contested hearing pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, not later than 60 days after issuance of the report under this subsection.

(2) If the results of the report issued under subsection (1) are disputed or if the commissioner determines that circumstances that the report was based on have changed, the commissioner shall issue a supplemental report to the report under subsection (1) which shall include a certification of whether or not a reasonable degree of competition exists in the worker's compensation insurance market. The supplemental report and certification shall be issued not later than November 15 immediately following the release of the report under subsection (1) that this report supplements and shall be supported by substantial evidence.

(3) All of the following shall be considered by the commissioner for purposes of subsections (1) and (2):

(a) The extent to which any insurer controls all or a portion of the worker's compensation insurance market. In making a determination under this subdivision, the commissioner shall use all insurers in this state, including self-insurers, group self-insurers as provided in chapter 65, and insurers writing risks under the placement facility created in chapter 23 as a base for calculating market share.

(b) Whether the total number of companies writing worker's compensation insurance in this state is sufficient to provide multiple options to employers.

(c) The disparity among worker's compensation insurance rates and classifications to the extent that such classifications result in rate differentials.

(d) The availability of worker's compensation insurance to employers in all geographic areas and all types of business.

(e) The residual market share.

(f) The overall rate level which is not excessive, inadequate, or unfairly discriminatory.

(g) Any other factors the commissioner considers relevant.

(4) The reports and certifications required under subsections (1) and (2) shall be forwarded to the governor, the clerk of the house, the secretary of the senate, all the members of the house of representatives standing committees on insurance and labor issues, and all the members of the senate standing committees on commerce and labor issues.

(5) Not later than 90 days after receipt of the final report and final certification, the legislature, by concurrent resolution, shall approve or disapprove the certification by a majority roll-call vote in each house. If the certification is approved, the commissioner shall proceed under section 2409a.

Sec. 2409a. If the commissioner certifies and the legislature resolves pursuant to section 2409 that a reasonable degree of competition does not exist with respect to the worker's compensation insurance market on a statewide basis or any geographic areas, classifications, kinds or types of risk, or that insurance is unavailable to a segment of the market who are, in good faith, entitled to obtain insurance through ordinary means, the commissioner shall create competition or availability where it does not exist. A plan for competition or availability adopted pursuant to this section shall be included in a report or supplemental report under section 2409. The plan shall only relate to those geographic areas, classifications, or kinds or types of risks where competition has been certified not to exist. The plan may include methods designed to create competition or availability as the commissioner considers necessary, and may provide for the commissioner to do 1 or more of the following:

(a) Authorize, by order, joint underwriting activities in a manner specified in the commissioner's order.

(b) Modify the rate approval process in a manner to increase competition or availability while at the same time providing for reasonably timely rate approvals, including prior approval or file and use processes.

(c) Order excess profits regulation. Excess profits regulation authorized by this subdivision shall be based upon rules promulgated pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. Excess profits shall include both underwriting profits and all after-tax investment or investment profit or loss from unearned premiums and loss reserves attributable to worker's compensation insurance. The commissioner, pursuant to excess profits regulation, may establish forms for the reporting of financial data of an insurer.

(d) Establish and require worker's compensation insurance rates, by order, which insurers must use as a condition of maintaining their certificate of authority. The order setting the rates shall take effect not less than 90 days nor more than 150 days after the order is issued.

Sec. 2409c. (1) By May 15, 2003 and by May 15 annually thereafter, the commissioner shall make an annual determination as to whether a reasonable degree of competition in the commercial liability insurance market exists on a statewide basis. If the commissioner determines that a reasonable degree of competition in the commercial liability insurance market does not exist on a statewide basis, the commissioner shall hold a public hearing and shall issue a report delineating specific classifications and kinds or types of insurance, if any, where a reasonable degree of competition does not exist. The report shall be based on relevant economic tests, including, but not limited to, those in subsection (3). The findings in the report shall not be based on any single measure of competition, but appropriate weight shall be given to all measures of competition. Any person who disagrees with the report and findings of the commissioner may request a contested hearing pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, not later than 60 days after issuance of the report under this subsection.

(2) If the results of the report issued under subsection (1) are disputed or if the commissioner determines that circumstances that the report was based on have changed, the commissioner shall issue a supplemental report to the report under subsection (1) which shall include a certification of whether or not a reasonable degree of competition exists in the commercial liability insurance market. The supplemental report and certification shall be issued not later than November 15 immediately following the release of the report under subsection (1) that this report supplements and shall be supported by substantial evidence.

(3) All of the following shall be considered by the commissioner for purposes of subsections (1) and (2):

(a) The extent to which any insurer controls the commercial liability insurance market, or any portion of the commercial liability insurance market.

(b) Whether the total number of companies writing commercial liability insurance in this state is sufficient to provide multiple options to commercial liability insurance purchasers.

(c) The disparity among commercial liability insurance rates and classifications to the extent that such classifications result in rate differentials.

(d) The availability of commercial liability insurance to commercial liability insurance purchasers in all geographic areas and all types of business.

(e) The residual market share.

Sec. 3515. (1) A health maintenance organization may provide additional health maintenance services or any other related health care service or treatment not required under this chapter.

(2) A health maintenance organization may have health maintenance contracts with deductibles. A health maintenance organization may have health maintenance contracts with copayments that are required for specific health maintenance services. Copayments for services required under section 3501(b), excluding deductibles, shall be nominal, shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee, and shall not be based on the provider's standard charge for the service. A health maintenance organization shall not require contributions be made to a deductible for preventative health care services. As used in this subsection, "preventative health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability.

(3) A health maintenance organization may accept from governmental agencies and from private persons payments covering any part of the cost of health maintenance contracts.

Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any deductibles and copayments, between the organization and its subscribers shall be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts shall not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates shall not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The commissioner may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new coverages.

(3) All health maintenance organization contracts shall include, at a minimum, basic health services.

Sec. 3528. (1) A health maintenance organization shall do all of the following:

(a) Establish written policies and procedures for credentialing verification of all health professionals with whom the health maintenance organization contracts and shall apply these standards consistently.

(b) Verify the credentials of a health professional before entering into a contract with that health professional. The health maintenance organization's medical director or other designated health professional shall have responsibility for, and shall participate in, health professional credentialing verification.

(c) Establish a credentialing verification committee consisting of licensed physicians and other health professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification.

(d) Make available for review by the applying health professional upon written request all application and credentialing verification policies and procedures.

(e) Retain all records and documents relating to a health professional's credentialing verification process for at least 2 years.

(f) Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

(2) A health maintenance organization shall obtain primary verification of at least all of the following information about an applicant to become a health professional with the health maintenance organization:

(a) Current license to practice in this state and history of licensure.

(b) Current level of professional liability coverage, if applicable.

(c) Status of hospital privileges, if applicable.

(3) A health maintenance organization shall obtain, subject to either primary or secondary verification at the health maintenance organization's discretion, all of the following information about an applicant to become an affiliated provider with the health maintenance organization:

(a) The health professional's license history in this and all other states.

(b) The health professional's malpractice history.

(c) The health professional's practice history.

(d) Specialty board certification status, if applicable.

(e) Current drug enforcement agency (DEA) registration certificate, if applicable.

(f) Graduation from medical or other appropriate school.

(g) Completion of postgraduate training, if applicable.

(4) A health maintenance organization shall obtain at least every 3 years primary verification of all of the following for a participating health professional:

(a) Current license to practice in this state.

(b) Current level of professional liability coverage, if applicable.

(c) Status of hospital privileges, if applicable.

(5) A health maintenance organization shall require all participating providers to notify the health maintenance organization of changes in the status of any of the items listed in this section at any time and identify for providers the individual at the health maintenance organization to whom they should report changes in the status of an item listed in this section.

(6) A health maintenance organization shall provide a health professional with the opportunity to review and correct information submitted in support of that health professional's credentialing verification application as follows:

(a) Each health professional who is subject to the credentialing verification process has the right to review all information, including the source of that information, obtained by the health maintenance organization to satisfy the requirements of this section during the health maintenance organization's credentialing process.

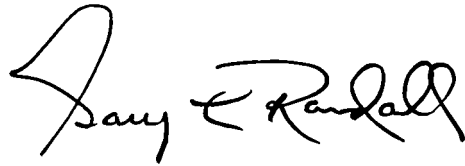
(b) A health maintenance organization shall notify a health professional of any information obtained during the health maintenance organization's credentialing verification process that does not meet the health maintenance organization's credentialing verification standards or that varies substantially from the information provided to the health maintenance organization by the health professional, except that the health maintenance organization is not required to reveal the source of information if the information is not obtained to meet the requirements of this section or if disclosure is prohibited by law.

(c) A health professional has the right to correct any erroneous information. A health maintenance organization shall have a formal process by which a health professional may submit supplemental or corrected information to the health maintenance organization's credentialing verification committee and request a reconsideration of the health professional's credentialing verification application if the health professional feels that the health carrier's credentialing verification committee has received information that is incorrect or misleading. Supplemental information is subject to confirmation by the health maintenance organization.

(7) If a health maintenance organization contracts to have another entity perform the credentialing functions required by this section, the commissioner shall hold the health maintenance organization responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of this section are met.

(8) Nothing in this act shall be construed to require a health maintenance organization to select a provider as a participating provider solely because the provider meets the health maintenance organization's credentialing verification standards, or to prevent a health maintenance organization from utilizing separate or additional criteria in selecting the health professionals with whom it contracts.

This act is ordered to take immediate effect.



Clerk of the House of Representatives.



Secretary of the Senate.

Approved _____

Governor.