Senate Fiscal Agency
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BILL ANALYSIS

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House Bill 4933 (Substitute S-1 as reported)
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Sponsor: Representative Tom Barrett (H.B. 4933)
Representative Robert L. Kosowski (H.B. 4934)
Representative Tom Leonard (H.B. 4935)
House Committee: Insurance
Senate Committee: Insurance

CONTENT

House Bill 4933 (S-1) would amend the Patient's Right to Independent Review Act to revise a number of provisions related to an individual's request for an external review of an adverse determination by his or her health carrier once he or she has exhausted the carrier's internal grievance process. Specifically, the bill would do the following:

-- Provide that a person who requested an expedited external review due to a life- or health-threatening medical condition would be considered to have exhausted the health carrier's internal grievance process.
-- Require a health carrier to notify a covered person that the carrier could waive its internal grievance process and the requirement for a covered person to exhaust that process before filing a request for an external review or an expedited external review; and that a covered person would be considered to have exhausted the internal grievance process if the carrier failed to comply with the requirements of the process, unless the failure were minor and did not prejudice or harm the covered person.
-- Require notices required under the Act to conform to Federal regulations.
-- After December 31, 2016, extend the time period in which a covered person may file a request for an external review from 60 days to 120 days following an adverse or final adverse determination.
-- Require the Director of the Department of Insurance and Financial Services (DIFS), within five days after receiving an external review request involving an experimental or investigational health service or treatment, to conduct a preliminary review to determine if the request met criteria prescribed in the bill.
-- Require a covered person who submitted an incomplete request for external review to provide the information or materials needed to complete the request within 30 days after receiving notice from the DIFS Director.
-- Require the reviewing entity, in making its recommendation regarding an external or expedited external review involving experimental or investigational service or treatment, to consider whether the service or treatment was approved by the U.S. Food and Drug Administration (FDA) and whether it was appropriate based on medical or scientific evidence or evidence-based standards.
-- Require an independent review organization to be accredited by a nationally recognized accrediting organization in order to be approved to conduct external reviews under the Act.
-- Include a nonprofit dental care corporation in the definition of "health carrier".

House Bill 4934 (S-1) would amend the Coordination of Benefits Act to revise the order of benefits determination with regard to an individual who is covered under multiple health benefit plans.

The Act prescribes the order and manner in which benefits must be determined, based on various factors including whether the claim or policy covers the person on whose expenses are based as a dependent; whether the person is a Medicare beneficiary; whether Medicare is secondary due to provisions of the Social Security Act; and, if the person is covered as a dependent minor child, whether his or her parents are divorced or legally separated, whether the custodial parent has remarried, and whether a divorce decree places financial responsibility for the child's health care expenses upon either parent. If these provisions do not establish an order of benefit determination, additional standards apply. The bill would delete all of these provisions.

Under the bill, if an individual were covered by two or more plans, the insurer that issued the primary plan would have to pay or provide benefits as if a secondary plan did not exist. In the case of an individual covered by more than one secondary plan, the bill would establish a number of rules to determine the order under which secondary plan benefits would be determined in relation to each other.

The bill would prescribe a time frame for an insurer that issued a contract before the bill's effective date to bring the contract into compliance with these amendments.

House Bill 4935 (S-1) would amend the Insurance Code to do the following:

-- Include a health maintenance organization (HMO) in the Code's general definition of "insurer".
-- Create an exception to a requirement that an application for life or disability insurance bear the signature of an insurance producer with regard to an application through the insurer's website, if the website contained a statement that the applicant could use an insurance producer to assist with the application at no cost to the applicant.
-- Revise the definition of "disability insurance".
-- Provide that claims filed during a grace period for certain individuals covered under a qualified health plan through a Federal health benefit exchange would not be considered clean claims and thus would not be subject to interest payments if they were not processed and paid within the Code's prescribed time period.
-- Revise the deadline by which an insurer must make a final determination in response to an insured's or enrollee's submission of an internal formal grievance.
-- Allow an insurer to modify an individual or group health insurance policy upon the policy's renewal.
-- Provide that guaranteed renewal of a health insurance policy would not be required in cases of noncompliance with minimum contribution or minimum participation requirements.
-- Prescribe steps that an insurer could take to satisfy a requirement for the delivery of an insurance form or required notice to a subscriber, insured, enrollee, or contract holder.
-- Specify that a disability policy that was a health insurance policy could insure the policyholder's family members up to age 26, rather than 19 as currently provided.
-- Include policies providing pediatric dental or pediatric vision benefits among those that may be offered to a policyholder's family members up to age 19.
-- For health insurance coverage provided in the individual market, require an insurer to be notified of the birth of a child and payment of any specific premium required to provide coverage for the child within 60 days after the child's birth, rather than 31 days as provided currently.

-- After December 31, 2017, provide that "insurer" would include a nonprofit dental care corporation with regard to a prohibition against an insurer's use of "most favored nation" clauses in provider contracts.
-- Delete a requirement that an insurer that offers health insurance policies requiring or providing a financial advantage to insured people to obtain services from providers who have entered prudent purchaser agreement, also to offer policies that do not require or encourage the use of those providers.
-- Delete provisions allowing an insurer to inquire about, underwrite, or charge a different premium on the basis of the physical or mental condition of an insured or applicant for insurance who is or has been a victim of domestic violence.
-- Revise the time frame for an insurer to notify an enrollee who requests an exception to the insurer's prescription drug formulary as to whether the request has been granted.
-- Delete a provision allowing an insurer to require an applicant for insurance to answer questions concerning family history.
-- Provide that if a policyholder canceled a disability insurance policy during the first 30 days after receiving it, the policyholder would be responsible for claims paid by the insurer that were incurred before the cancelation's effective date.
-- Delete provisions allowing a policyholder to decline mandatory substance use disorder coverage if that coverage increases policy premiums by at least 3%, and requiring substance use disorder coverage to provide for a minimum dollar amount of benefits per year.
-- Increase the premium discount that health insurance policies may offer for participation in wellness programs.
-- Allow an insurer to include in a disability insurance policy a statement that the insurer is not liable for any loss to which a contributing cause was the insured's engagement in illegal activity, including operating a vehicle while intoxicated and operating a methamphetamine laboratory.
-- Allow an insurer, subject to the DIFS Director's approval, to deny health insurance coverage in the group or individual market if the insurer did not have the network capacity to offer additional coverage.
-- Revise requirements for the composition of an HMO's governing body.
-- Delete a provision limiting coinsurance for "basic health services" under an HMO contract to 50% of the HMO's provider reimbursement rate, revise the definition of "basic health services", and require an HMO to offer basic health services to large employers rather than in all contracts.
-- Revise requirements related to an HMO's credentialing verification of the health professionals with whom it contracts.
-- Delete a number of provisions regulating prudent purchaser contracts issued by an HMO.
-- Allow an enrollee of an insolvent HMO to obtain substitute coverage through an American health benefit exchange operating pursuant to the Patient Protection and Affordable Care Act.
-- Beginning January 1, 2018, define "small employer" with regard to small employer group coverage as "any person engaged in business that, during the preceding calendar year, employed an average of at least 1 but not more than 50 full-time equivalent employees and who employs at least 1 full-time equivalent employee on the first day of the plan year".
-- Require the DIFS Director to establish defined geographic areas for adjusting premiums in the small employer group health coverage market, rather than allow insurers to establish the areas.
-- Delete a number of provisions related to sole proprietors in the small employer group market.

-- Delete references to a nonprofit health care corporation under the Nonprofit Health Care Corporation Reform Act (which previously regulated Blue Cross Blue Shield of Michigan before it converted to a nonprofit mutual company regulated under the Insurance Code).

The bill would repeal Chapter 36 (Group and Blanket Disability Insurance), but would reenact similar provisions applicable to group and blanket disability policies in Chapter 34 (Disability Insurance Policies).

House Bills 4933 (S-1) and 4934 (S-1) are tie-barred to House Bill 4935, and House Bill 4935 (S-1) is tie-barred to the other two bills.

MCL 500.1903 et al. (H.B. 4933)
550.252-550.254 (H.B. 4934)
500.106 et al. (H.B. 4935)

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

The bills would have a neutral fiscal impact on the Department of Insurance and Financial Services and no fiscal impact on local units of government. The bills likely would require DIFS to promulgate rules, establish rulings, and take other administrative actions with respect to the statutory changes in the bills. These actions would create new indeterminate administrative costs that probably would be borne by the Insurance Bureau Fund, which derives revenue from regulatory fees imposed on insurers in Michigan. Since the statutory formula for the fees takes into account the Department's costs to regulate insurance, these new costs would presumably be taken into consideration and essentially hold DIFS harmless. In fiscal year 2014-15, a total of $18.0 million was deposited into the Insurance Bureau Fund.

Date Completed: 6-2-16

Fiscal Analyst: Josh Sefton