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BILL ANALYSIS

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House Bill 4933 (Substitute H-1 as passed by the House)
House Bill 4934 (Substitute H-2 as passed by the House)
House Bill 4935 (Substitute H-1 as passed by the House)
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

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CONTENT

House Bill 4933 (H-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 carrier that failed to comply with the requirements of its internal grievance process would be considered to have exhausted 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.**
-- **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".

<u>House Bill 4934 (H-2)</u> 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.

<u>House Bill 4935 (H-1)</u> 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.
-- 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 the time frame for the DIFS Director to disapprove a disability insurance policy form, and expand the grounds for disapproval.
-- Eliminate specific rating factors that may be used in the individual or small group market, and instead require health insurance policy rates to be fair, sound, and reasonable in relation to the services provided.
-- 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.
-- 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 (H-1) and 4934 (H-2) are tie-barred to House Bill 4935, and House Bill 4935 (H-1) is tie-barred to the other two bills.

House Bill 4933 (H-1)

Scope of Act

The Patient's Right to Independent Review Act applies to all health carriers that provide or perform utilization review. The bill would delete the reference to the provision or performance of utilization review.

"Health carrier" means a person who is subject to Michigan insurance laws and regulations, or subject to the jurisdiction of the Director of the Department of Insurance and Financial Services, who contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. The term includes a sickness and accident insurance company, a health maintenance organization, a nonprofit health care corporation, or any other person providing a plan of health insurance, health benefits, or health services. The term does not include a State department or agency administering Medicaid. Under the bill, "health carrier" also would include a nonprofit dental care corporation operating under Public Act 125 of 1963 (which governs nonprofit dental care corporations).

"Utilization review" means a set of formal techniques designed to monitor the use, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of health care services, procedures, or settings.

Notice of Adverse Determination

Under the Patient's Right to Independent Review Act, when a health carrier sends written notice of an adverse determination to a covered person, the health carrier must provide written notice of the internal grievance and external review processes. Except as otherwise provided, a request for an external review may not be made until the covered person has exhausted the health carrier's internal grievance process provided for by law.

"Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and has been denied, reduced, or terminated. The bill would refer to a health care service that is a covered benefit. The bill also would refer to a determination that an admission, availability of care, etc., based on the information provided, does not meet the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness.

The written notice of the right to request an external review for an adverse determination issued before the service is provided must include a statement informing the covered person of both of the following:

-- If he or she has a medical condition such that the time frame for completion of an expedited internal grievance would seriously jeopardize his or her life, health, or ability to regain maximum function, as substantiated by a physician, the concerned person or his or her authorized representative may file a request for an expedited external review concurrently with the request for an expedited internal grievance.
-- The covered person or his or her authorized representative may file a grievance under the carrier's internal grievance process, but if the carrier has not issued a written decision to the covered person or authorized representative within the required time, the covered person or representative may file a request for external review and is considered to have exhausted the carrier's internal grievance process.

Under the bill, in the case of a covered person who requests an expedited external review because his or her life, health, or ability to regain maximum function would be jeopardized

by waiting, the person would be considered to have exhausted the carrier's internal grievance process.

The bill also would require the statement to inform the covered person of the following:

-- 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.
-- A carrier that failed to comply with the requirements of its internal grievance process would be considered to have exhausted the process, unless the failure or failures were based on de minimis violations that did not cause, and were not likely to cause, prejudice or harm to the covered person.

Currently, the written notices required under the Act must be in plain English. The bill would delete this requirement, and instead would require a written notice to be provided in a culturally and linguistically appropriate manner, as required by Federal regulations.

The bill provides that a health carrier could satisfy a requirement for the delivery of a notice to a covered person under the Act by complying with Federal regulations with respect to the use of electronic communication.

(A "covered person" is a policyholder, subscriber, member, enrollee, or other individual participating in a health benefit plan, i.e., a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of covered health care services.)

Request for External Review; Preliminary Review

Except for a request for expedited external review, all requests for external review must be made in writing to the DIFS Director. Within 60 days after receiving a notice of an adverse determination or final adverse determination, a covered person or his or her authorized representative may file a request for an external review with the Director, who immediately must notify the health carrier that made the determination. The bill would extend the time frame for filing the request from 60 days to 120 days.

("Final adverse determination" would mean an adverse determination involving a covered benefit that has been upheld by a health carrier or its designee utilization review organization at the completion of the carrier's internal grievance process procedures.)

Within five days after receiving a request for external review, the Director must complete a preliminary review of the request to determine whether the individual is or was a covered person in the health benefit plan when the service was requested or provided; whether the service reasonably appears to be a covered service under the health benefit plan; whether the covered person has exhausted the carrier's internal grievance process, if applicable; whether the covered person has provided all of the required information and forms necessary to process an external review; and whether the service appears to involve issues of medical necessity or clinical review criteria.

Under the bill, if a request involved issues of experimental or investigational service or treatment, within five business days after the receiving the request, the Director also would have to complete a preliminary review to determine all of the following:

-- Whether the individual is or was a covered person in the health benefit plan at the time the health care service was requested or, for a retrospective review, was a covered person when the service was provided.

-- Whether the recommended or requested service or treatment was a covered benefit under the person's health benefit plan except for the carrier's determination that the service or treatment was experimental or investigational for a particular medical condition, and was not explicitly listed as an excluded benefit under the person's plan with the carrier.
-- Whether the covered person's treating physician had certified that at least one of the following applied: standard services or treatments had not been effective in improving the covered person's condition or were not medically appropriate for that person, or there was no available standard service or treatment covered by the carrier that was more beneficial than the recommended or requested service or treatment.
-- Whether the covered person had exhausted the carrier's internal grievance process, unless he or she was not required to do so.
-- Whether the covered person had provided all of the information and forms required by the DIFS Director that were necessary to process an external review, including the health information release form.

The Director also would have to determine whether the covered person's treating physician had done either of the following:

-- Recommended a service or treatment that he or she certified was likely to be more beneficial to the covered person, in the physician's opinion, than any available standard services or treatments.
-- If the physician were a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, certified that scientifically valid studies using accepted protocols demonstrated that the requested service or treatment was likely to be more beneficial to the covered person than any available standard health care services or treatments.

Currently, upon completing a preliminary review, the DIFS Director immediately must notify the covered person and, if applicable, his or her authorized representative, as to whether the request is complete and had been accepted for external review. Upon accepting a request for external review, the Director must include in the notice a statement that the covered person or his or her authorized representative may submit additional information and supporting documentation that the reviewing entity will consider when conducting the review. The Director also must notify the health carrier of the acceptance of the request for external review. If a request is not accepted because it is not complete, the Director must inform the covered person and, if applicable, his or her representative of the information or materials needed to make the request complete. The bill would require the covered person or his or her authorized representative, as applicable, to provide the information or materials identified by the Director within 30 days after receiving the notification.

These notification requirements also would apply when the Director completed a preliminary review of a request concerning experimental or investigational service or treatment.

External & Expedited External Review

Under the Act, if a request is accepted for external review and appears to involve issues of medical necessity or clinical review criteria, the DIFS Director must assign an independent review organization that is approved to conduct external reviews. The review organization must give to the Director a recommendation on whether to uphold or reverse the health carrier's adverse determination or final adverse determination. If a request is accepted for external review, does not appear to involve issues of medical necessity or clinical review criteria, and appears to involve only purely contractual provisions of a health benefit plan, the Director may keep the request and conduct his or her own external review or may assign an independent review organization.

A covered person or his or her authorized representative may request an expedited external review within 10 days after receiving an adverse determination if both of the following apply:

-- The adverse determination involves a medical condition for which the time frame for completion of an expedited internal grievance would seriously jeopardize the covered person's life, health, or ability to regain maximum function as substantiated by a physician.
-- The covered person or her or her authorized representative has filed a request for an expedited internal grievance.

If the Director determines that the expedited request meets the Act's reviewability requirements, he or she must assign an approved independent review organization to conduct the expedited review and make a recommendation to the Director on whether to uphold or reverse the adverse or final adverse determination.

Within seven business days, or, in the case of an expedited request, 12 hours, after receiving a notice that a request for external review has been accepted, the health carrier or its designee utilization review organization must give the reviewing entity the documents and any other information considered in making the adverse determination or final adverse determination. The reviewing entity must review all of the information and documents received from the health carrier and any other information submitted in writing by the covered person or his or her authorized representative that has been forwarded by the DIFS Director. Additionally, to the extent the information or documents are available and the reviewing entity considers them appropriate, the reviewing entity must consider specified documents or information, including the covered person's pertinent medical records and the attending health care professional's recommendation, in reaching a recommendation.

Under the bill, if a request for an external review or expedited external review involved issues of experimental or investigational service or treatment, in addition to the specified documents and information, the reviewing entity, in reaching a recommendation, would have to consider whether either of the following applied:

-- The recommended or requested health care service or treatment had been approved by the FDA, if applicable, for the condition.
-- Medical or scientific evidence or evidence-based standards demonstrated that the expected benefits of the recommended or requested service or treatment were more likely than not to be more beneficial to the covered person than the benefits of any available standard service or treatment and the adverse risks would not be substantially increased over those of available standard services or treatments.

Independent Review Organization Approval

To be approved by the DIFS Director to conduct external reviews, an independent review organization must do both of the following:

-- Have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited process that include, at a minimum, a quality assurance mechanism that meets criteria prescribed in the Act.
-- Agree to maintain and give the Director an annual report on the external review requests submitted to the organization, in the aggregate and for each health carrier.

Under the bill, the independent review organization also would have to be accredited by a nationally recognized private accrediting organization approved by the Director.

House Bill 4934 (H-2)

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. Instead, if an individual were covered by two or more plans, the rules for determining the order of benefit payments would be as described below.

The insurer that issued the primary plan would have to pay or provide benefits as if a secondary plan did not exist.

If the individual were covered by more than one secondary plan, the order of benefit determination rules (described below) would determine the order under which secondary plan benefits were determined in relation to each other. An insurer that issued a secondary plan would have to take into consideration the benefits of the primary plan and the benefits of any other plan that were, under the Act, determined to be payable before those of the secondary plan.

A plan that did not contain order of benefit determination provisions that were consistent with the Act would always be the primary plan unless the provisions of both plans, regardless of this provision, stated that the complying plan was primary.

If the primary plan were a closed panel plan and the secondary plan were not, the insurer that issued the secondary plan would have to pay or provide benefits as if it were the primary plan if a covered person used a nonpanel provider, except for emergency services or authorized referrals that were paid or provided by the insurer that issued the primary plan.

("Plan" would mean a form of health care coverage with which coordination is allowed. Separate parts of a plan for members of a group that were provided through alternative contracts and that were intended to be part of a coordinated package of benefits would be considered one plan, and there would not be coordination of benefits among the separate parts. If benefits were coordinated under a plan, the contract would have to state the types of coverage that would be considered in applying the COB provision of the contract. "Plan" would include any of the following:

- Group and nongroup insurance contracts and subscriber contracts.
- Uninsured arrangements of group or group-type coverage.
- Group and nongroup coverage through closed panel plans.
- Group-type contracts.
- The medical care components of long-term care contracts, including skilled nursing care.
- Medicare or other governmental benefits as permitted by law, except as otherwise provided.
- Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
- Group and nongroup dental insurance contracts and subscriber contracts issued by a dental care corporation.

"Primary plan" would mean a plan under which benefits for an individual's health care coverage are determined without taking into consideration the existence of any other plan. A plan would be primary if either 1) the plan had no order of benefit determination rules or its rules differed from those authorized under the Act, or 2) all plans covering the individual used the order of benefit determination rules required under the Act and, under those rules, the benefits payable under the plan were determined to be payable first.

"Secondary plan" would mean a plan that is not a primary plan.)

"Closed panel plan" would mean a plan that provides health benefits to covered people primarily in the form of services through a panel of providers that have contracted with or are employed by the insurer that issued the plan and that excludes benefits for services provided by other providers, except in cases of emergency or referral by panel providers.)

The order in which benefits were payable by insurers that issued plans would be determined by using the first of the following rules that applied:

The Nondependent/Dependent Rule. If the individual were not a dependent but were an employee, member, subscriber, policyholder, or retiree under one plan and a dependent under another plan, the order of payment of benefits under the plan would be determined as follows:

-- Except as otherwise provided, the plan that covered the individual other than as a dependent would be the primary plan and the plan that covered the individual as a dependent would be the secondary plan.
-- If the individual were a Medicare beneficiary and, as a result of certain provisions of the Social Security Act, Medicare was secondary to the plan covering him or her as a dependent and primary to the plan covering him or her as other than a dependent, the order of benefits would be reversed and the plan covering the individual as other than a dependent would be the secondary plan and the plan covering the individual as a dependent would be the primary plan.

The Dependent Covered under more than One Plan Rule. If the individual were a dependent child, unless there was a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the child would be determined as described below.

If the child's parents were married or living together, whether or not they had ever been married, the plan of the parent whose birthday fell earlier in the year would be the primary plan. If both parents had the same birthday, the plan that had covered the parent longer would be the primary plan.

If the child's parents were divorced, separated, or not living together, whether or not they had ever been married, the following would apply:

-- If a court order or judgment stated that one of the parents was responsible for the child's health care expenses or health care coverage and the insurer that issued that parent's plan had actual knowledge of the terms of the order or judgment, that plan would be the primary plan.
-- If the parent with responsibility had no health care coverage for the child's expenses, but his or her spouse did, the spouse's plan would be the primary plan.
-- If a court order or judgment stated that both parents were responsible for the child's health care expenses or health care coverage, the order of benefits would be determined in the manner prescribed for a child whose parents were married or living together.

-- If a court order or judgment stated that the parents had joint custody without specifying that one parent had responsibility for the child's health care expenses or coverage, the order of benefits would be determined in the manner prescribed for a child whose parents were married or living together.
-- If there were no court order or judgment allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child would be as follows, in the following order of priority: 1) the plan covering the custodial parent, 2) the plan covering the custodial parent's spouse, 3) the plan covering the noncustodial parent, and 4) the plan covering the noncustodial parent's spouse.

If a child were covered under more than one plan of individuals who were not his or her parents, the order of benefits would be determined in the manner prescribed for a child whose parents were married or living together, or divorced, separated, or not living together, as applicable, as if those individuals were the child's parents.

If the child were covered under either or both parents' plans and also were covered as a dependent under his or her spouse's plan, the order of benefits would be as determined under the longer or shorter length of coverage rule (described below). If the child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits would be determined by applying the birthday rule to his or her parents, as applicable, and his or her spouse.

The Active, Retired, or Laid-Off Employee Rule. If the individual were an active employee, laid-off employee, or retired employee, or were a dependent of any of those individuals, the order of payment of benefits under the plans covering the individual would be determined as described below.

The plan that covered the individual as an active employee or as a dependent of an active employee would be the primary plan. The plan that covered the individual as a laid-off or retired employee, or the dependent of such an individual, would be the secondary plan.

If the other plan that covered the individual did not have the rule described above and the plans did not agree on the order of benefits, the rule described above would not apply.

The Continuation Coverage Rule. If the individual had coverage under a right of continuation pursuant to Federal or State law, the plan that covered him or her as a dependent of an employee, member, subscriber, enrollee, or retiree would be the primary plan, and the plan that covered him or her under the continuation coverage would be the secondary plan. This rule would not apply if the other plan that covered the individual did not have such a rule and, as a result, the plans did not agree on the order of benefits.

The Longer or Shorter Length of Coverage Rule. If none of the rules described above determined the order of benefits, the plan that had covered the individual for the longer period of time would be the primary plan and the plan that had covered him or her for the shorter period of time would be the secondary plan. To determine the length of time an individual had been covered under a plan, two successive plans would be treated as one if the individual were eligible under the second plan within 24 hours after coverage under the first plan ended. None of the following changes would constitute the start of a new plan:

-- A change in the amount or scope of a plan's benefits.
-- A change in the entity that pays, provides, or administers the plan's benefits.
-- A change from one type of plan to another, such as from a single-employer plan to a multiple-employer plan.

If the insurers that issued plans could not agree on the order of benefits within 30 days after they received all of the information needed to pay the claim, they immediately would have to pay the claim in equal shares and determine their relative liabilities following payment. An insurer would not have to pay more than it would have paid had the plan it issued been the primary plan.

In determining the amount to be paid on a claim by the insurer that issued a secondary plan, if the insurer wished to coordinate benefits, it would have to calculate the benefits it would have paid in the absence of other health care coverage and apply that amount to any allowable expense under its plan that was unpaid under the primary plan. The insurer could reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim did not exceed 100% of the total allowable expense for the claim. If an insurer that issued a plan were advised by a covered person that all plans covering him or her were high-deductible health plans and the person intended to contribute to a health savings account established in accordance with the Internal Revenue Code, the primary high-deductible plan's deductible would not be an allowable expense, except for any health care expense incurred that might not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code. (Under that section, a plan may not fail to be treated as a high-deductible health plan by reason of failing to have a deductible for preventive care.)

"Allowable expense" would mean a health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering an individual. The amount of a reduction could be excluded from allowable expense if a covered person's benefits were reduced under a primary plan for either of the following reasons:

- The covered person did not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services.
- The covered person had a lower benefit because he or she did not use a preferred provider.

House Bill 4935 (H-1)

Insurance Code Compliance

A person may not transact an insurance or surety business in Michigan, or relative to a subject resident, located or to be performed in Michigan, without complying with the applicable provisions of the Insurance Code. Under the bill, this provision also would apply to an HMO.

As used in the Code generally, "insurer" means an individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds organization, fraternal benefit society, or other legal entity, engaged or attempting to engage in the business of making insurance or surety contracts. The bill provides that except as otherwise provided and unless the context required otherwise, "insurer" would include an HMO.

"Disability Insurance" Definition

Under the Code, "disability" insurance is insurance against bodily injury or death by accident, or against disability on account of sickness or accident, including the granting of specific hospital benefits and medical, surgical, and sick care benefits to a person, family, or group, subject to limitations prescribed with respect to the insurance.

Under the bill, instead, "disability" insurance would mean insurance against bodily injury or death by accident, or against disability on account of sickness or accident. Unless specifically

excluded in Chapter 34 (Disability Insurance Policies) of the Code, the term would include health insurance issued to an individual, family, or group, subject to limitations that are prescribed with respect to the insurance.

Processing & Payment Procedures

The Code prescribes procedures that each health professional, health facility, home health care provider, and durable medical equipment provider must use in billing for services rendered and each health plan must use in processing and paying claims for those services. A clean claim must be paid within 45 days after the health plan receives it, and bears annual interest at a rate of 12% if not paid within that time period.

Under the bill, a health plan that was a qualified health plan for the purposes of Federal regulations pertaining to termination of coverage or enrollment through an exchange and that, as required under those regulations, provided a three-month grace period to an enrollee who was receiving advance payments of the premium tax credit and who had paid one full month's premium, could pend claims for services rendered to the enrollee in the second and third months of the grace period. A claim during the second and third months would not be a clean claim and interest would not be payable on it if the health plan had complied with the notice requirements of the Federal regulations pertaining to termination of exchange enrollment or coverage.

The bill specifies that the timely processing and payment provisions would not apply to a nonprofit dental care corporation.

Internal Formal Grievance Procedure

Except as otherwise provided, the Code requires each insurer to establish an informal grievance procedure, to be approved by the DIFS Director, by which covered individuals may appeal an adverse determination by the insurer. The procedure must provide that the insurer will make a written final determination within 35 days after an insured or enrollee submits a written grievance. The bill would eliminate the 35-day deadline, and instead require that the procedure provide for the insurer's final determination within 30 days after submission of a preservice grievance and 60 days after submission of a postservice grievance. Additionally, if the insurer's procedure for insureds or enrollees covered under a group policy or plan included two steps to resolve a grievance, the time for the first step could not be longer than 15 days for a preservice grievance or 30 days for a postservice grievance.

The bill would eliminate requirements that notices given with regard to the grievance procedure be in plain English, and instead would require that they be provided in a culturally and linguistically appropriate manner as required under Federal regulations.

Currently, "adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated; or failure to respond in a timely manner to a request for a determination. Under the bill, instead, the term would mean any of the following:

-- A determination by an insurer or its designee utilization review organization that a request for a benefit, on application of any utilization review technique, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
-- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by an insurer or its designee utilization review organization of a covered person's eligibility for coverage from the insurer.

-- A prospective or retrospective review determination that denies, reduces, or terminates or failes to provide or make payment, in whole or in part, for a benefit.
-- A rescission of coverage determination.
-- Failure to respond in a timely manner to a request for a determination.

Health Insurance Policy Renewal

Except as otherwise provided, an insurer that delivers, issues for delivery, or renews in Michigan a health insurance policy must renew it or continue it in force at the option of the individual or, for a group plan, at the option of the plan sponsor.

Under the bill, at the time of renewal of an individual health insurance policy, the insurer could modify the policy if the modification were consistent with State and Federal law and were effective on a uniform basis among all individuals with coverage under the policy. At the time of renewal of a group policy, the insurer could modify the policy.

Guaranteed renewal of a health insurance policy is not required in cases of fraud, intentional misrepresentation of material fact, or lack of payment, if the insurer no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area. The bill provides that guaranteed renewal also would not be required in cases of noncompliance with minimum contribution requirements or minimum participation requirements.

Approval of Policy Forms; Delivery to Insured

An insurer may not deliver or issue for delivery in Michigan a basic insurance policy form or annuity contract form, a printed rider or indorsement form or form of renewal certificate, or a group certificate in connection with a policy or contract, unless a copy is filed with DIFS and approved by the Director as conforming with the Code's requirements and not inconsistent with the law. The Director may not approve a form that provides for or relates to an insurance policy or annuity contract for personal, family, or household purposes if it fails to obtain a prescribed readability score or meet other applicable Code requirements.

In determining the readability score, the method prescribed in the Code must be applied to a policy form or a contract together with a rider or indorsement form usually associated with the policy form or contract. The bill provides that the method could be applied to a group of policy, contract, rider, or indorsement forms that had substantially the same language resulting in a single readability score for those forms. The bill also provides that the method could not be applied to medical terms that were included in the form for coverage purposes.

Upon written notice to an insurer, the DIFS Director may disapprove, withdraw approval, or prohibit the issuance, advertising, or delivery of a form to any person in Michigan if the form violates the Code; contains inconsistent, ambiguous, or misleading clauses; or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy. The bill specifies that the Director could review the forms on a case-by-case basis.

If a form is disapproved or approval is withdrawn, the insurer is entitled to a hearing before the Director or a deputy director within 30 days. After the hearing, the Director must make findings of fact and law and affirm, modify, or withdraw his or her original order of decision. The bill would prohibit an insurer from issuing the form after a final determination of disapproval or withdrawal of approval.

Notwithstanding any provision of the Code to the contrary, the bill provides that a health insurer could satisfy a requirement for the delivery of an insurance form or required notice to a subscriber, insured, enrollee, or contract holder by doing all of the following:

-- Taking appropriate and necessary measures reasonably calculated to ensure that the system for furnishing a form or notice resulted in the actual receipt of a delivered form or notice and protected the confidentiality of the recipient's personal information.
-- Ensuring that an electronically delivered form or notice was prepared and furnished in a manner consistent with the style, format, and content requirements applicable to the particular form or notice.
-- Upon request, delivering to the subscriber, insured, enrollee, or contract holder a paper version of an electronically delivered form or notice.

Disability Insurance Policies

The bill would repeal Chapter 36 (Group and Blanket Disability Insurance), and would amend Chapter 34 (Disability Insurance Policies) to allow an insurer authorized to write disability insurance in Michigan to issue group disability insurance policies.

An insurer may not deliver or issue for delivery in Michigan a disability insurance policy unless all of the following requirements are met:

-- The entire money and other considerations for the policy are expressed in the policy.
-- The time the insurance takes effect and terminates is expressed in the policy.
-- Except as otherwise provided, only one individual is insured under the policy.

A disability insurance policy may insure any two or more eligible members of a family, including husband, wife, dependent children or any children under a specified age that may not exceed 19 years, and any other individual dependent upon the policy holder.

Under the bill, these requirements would apply to an individual or family disability insurance policy. Also, the age specified in the policy could not exceed 19 years or, if the policy were a health insurance policy, 26 years.

Prescription Drug Formulary

An insurer that delivers, issues for delivery, or renews in Michigan a health insurance policy that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary must provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative.

The insurer must give notice as to whether an exception has been granted within 24 hours after receiving all information necessary to determine whether it should be granted. The bill would delete this requirement. Instead, on a request for an expedited review of coverage for a nonformulary alternative based on exigent circumstances, an insurer would have to make a determination and notify the enrollee or the enrollee's designee and the prescribing physician or other prescriber, as appropriate, of the determination within 24 hours after receiving the request. For purposes of this requirement, exigent circumstances would exist when an enrollee was suffering from a health condition that could seriously jeopardize his or her life, health, or ability to regain maximum function, or when he or she was undergoing a current course of treatment using a nonformulary drug.

If exigent circumstances did not exist, an insurer would have to make a determination on coverage for a nonformulary alternative and notify the enrollee or his or her designee and the prescribing physician or another prescriber, as appropriate, of the determination within 72 hours after receiving the request.

Substance Use Disorder

Under the Code, an insurer that delivers, issues for delivery, or renews in Michigan a health insurance policy must provide coverage for intermediate and outpatient care for substance use disorder.

In the case of group health insurance policies, if the premium for a group policy would increase by 3% or more because of the provision of this required coverage, the master policyholder has the option to decline the substance use disorder coverage. In the case of individual policies, if the total premium for all of an insurer's individual policies would be increased by 3% or more because of the provision of substance use disorder coverage, the named insured of each policy has the option to decline the required coverage. The bill would delete these provisions.

The required substance use disorder coverage must provide for a minimum of $1,500 in benefits for intermediate and outpatient care for substance abuse per individual per year. The minimum must be adjusted annually in accordance with the annual average percentage change in the U.S. consumer price index. The bill would delete these requirements.

Wellness Programs

An insurer that delivers, issues for delivery, or renews in Michigan a group health insurance policy may offer group wellness coverage. An insurer may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, and/or deductibles for participation in any health behavior wellness, maintenance, or improvement program offered by the employer. Any rebate of premium provided by the insurer is presumed to be appropriate unless credible data demonstrate otherwise, but may not exceed 30% of paid premiums unless approved by the DIFS Director. With regard to tobacco cessation programs, the bill would increase the maximum allowed discount to 50% of paid premiums.

The Code also allows an insurer to offer individual and family wellness coverage. The maximum rebate of premium allowed for individual and family policies is 30%, unless otherwise approved by the Director. The bill would increase this amount to 50%.

Under the bill, a health behavior wellness, maintenance, or improvement program could include other requirements in addition to those that were specific to health behavior wellness, maintenance, or improvement, if the program, taken as a whole, met the intent of the Code's wellness program provisions.

Denial of Health Insurance Coverage

Under the bill, subject to approval by the DIFS Director, an insurer could deny health insurance coverage in the group or individual market if the insurer did not have the network capacity to offer additional coverage. In that case, the insurer would have to act uniformly with regard to all employers or individuals in the group or individual market. The insurer would have to act without regard to the claims experience of an individual or employer and its employees and the employee's dependents and without regard to any health-status-related factor relating to the individual or employer and its employees and the employees' dependents.

Subject to the Director's approval, an insurer that denied coverage to an employer or individual under these circumstances could not offer coverage in the group or individual market, as applicable, before the later of the 181st day after denying the coverage or the date

the insurer demonstrated to the Director that it had sufficient network capacity or financial reserves, as applicable, to underwrite additional coverage.

Also, subject to the Director's approval, a denial of coverage would not limit the insurer's ability to renew coverage already in force or relieve the insurer of the responsibility to renew the coverage.

The Director could provide for the application of the coverage denial provision on a service-area-specific basis for HMOs.

Disapproval of Policy Form or Rate

Under Section 2242 of the Code, within 30 days after the filing of a disability insurance policy form applicable to individual or family expense coverage, the DIFS Director may disapprove the form for any of the following reasons, subject to the Code's requirements as to notice, hearing, and appeal:

-- The benefits provided under the policy are unreasonable in relation to the premium charged.
-- The policy contains a provision that is unjust, unfair, inequitable, misleading, or deceptive or that encourages misrepresentation of the policy.
-- The policy does not comply with other provisions of law.

The bill would repeal Section 2242, but would reenact similar provisions in Chapter 34 with several changes. Under the bill, the Director also could disapprove a disability insurance policy rate, and the deadline for disapproval would be extended from 30 days to 60 days. The bill would expand the grounds for disapproval to include that, with respect to a health insurance policy, the rate was unreasonably lower than what was necessary to meet the insurer's expenses for providing the coverage and would have an anticompetitive effect or result in predatory pricing in relation to coverage offered by other insurers.

The bill provides that the authority to disapprove a policy form or rate would not apply to a rate for a health insurance policy that was the result of collective bargaining and that affected only the enrollees or insureds who were members of the group engaged in the collective bargaining. An insurer, however, could file a rate with the Director within 60 days after the policy's effective date.

Section 2242 also authorizes the Director to withdraw his or her approval of a policy form at any time based on any of the grounds listed for disapproval of a form. An insurer may not issue the form after the effective date of the withdrawal. The bill would reenact these provisions in Chapter 34, but would refer to a policy form or rate.

The bill specifies that, with regard to these provisions, "insurer" would include a nonprofit dental care corporation.

Premium Rate Factors

Under the Code, the premium rate charged by an insurer, HMO, or nonprofit health care corporation for health insurance coverage offered through a policy or certificate delivered, issued for delivery, or renewed in Michigan on or after January 1, 2014, in the individual or small group market may vary based only on the following factors:

-- Whether the policy or certificate covers an individual or a family.
-- The rating area.
-- Age, except the premium rate may not vary by more than three to one for adults for all plans other than child-only plans.

-- Tobacco use, except that the premium rate may not vary by more than 1.5 to one.

The bill would delete this provision. Instead, a health insurance policy and the rates for it, including any deductibles, copayments, and coinsurances, would have to be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating policies could not be unfairly discriminatory.

A health insurance policy could not discriminate on the basis of race, color, creed, national origin, residence within the approved service area, if applicable, lawful occupation, sex, handicap, or marital status; however, marital status could be used to classify individuals or risks for the purpose of insuring family units. The DIFS Director could approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential were supported by sound actuarial principles and a reasonable classification system and were related to the actual and credible loss statistics or reasonably anticipated experiences for new coverage.

A healthy lifestyle program as defined in Section 3517 would not be subject to the Director's approval and would not have to be supported by sound actuarial principles or a reasonable classification system, or be related to actual and credible loss statistics or reasonably anticipated experience for the coverage. (Under Section 3517, "healthy lifestyle program" means a program recognized by an HMO that enhances health or reduces risk of disease. The bill would refer also to a program that educates enrollees on health-related matters. The bill provides that a healthy lifestyle program could include other requirements in addition to those that enhance health, educate enrollees on health-related matters, or reduce risk of disease if the program, taken as a whole, met the statutory intent.)

Inducement to Deny Services

The bill would prohibit an insurer from using any financial incentive or making any payment to a health professional that acted directly or indirectly as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services. This prohibition would not preclude payment arrangements that were not tied to specific medical decisions or prohibit the use of risk sharing as otherwise authorized in Chapter 34.

Health Maintenance Organizations

Governing Body. The Code provides that, by the end of the first 12 months of operation, an HMO's governing body must have at least one-third of its membership consisting of adult enrollees of the organization who are not compensated officers, employees, stockholders who own more than 5% of the organization's shares, or other individuals responsible for the conduct of, or financially interested in, the organization's affairs. The bill would delete this requirement.

The bill would require an HMO's governing body to include at least one individual who represented the HMO's membership. An HMO that was under contract with the State to provide medical services under the Medicaid program would have to comply with either of the following requirements:

-- At least one-third of the governing body would have to be representatives of its membership consisting of enrollees who were not compensated officers, employees, or other individuals responsible for the conduct of, or financially interested in, the organization's affairs.
-- The HMO would have to establish a consumer advisory council that reported to the governing body.

The consumer advisory council would have to include at least one enrollee, one family member or legal guardian of an enrollee, and one consumer advocate.

HMO Regulation. The bill would delete a requirement that the DIFS Director regulate the business and financial aspects of HMO operations to assure that they are financially sound and follow acceptable business practices.

Among other things, the Code requires an HMO to provide in the geographic area it serves health maintenance services that are available, accessible, and provided as promptly as appropriate to each of its enrollees in a manner that assures continuity, and are available and accessible to enrollees 24 hours per day and seven days per week for the treatment of emergency episodes of illness or injury. The bill would refer to the HMO's service area rather than its geographic area, and delete the references to availability, accessibility, and promptness in a manner that ensures continuity.

The bill would delete a requirement that an HMO provide adequate arrangements for a continuous evaluation of the quality of health care.

The bill also would delete a requirement that an HMO provide that reasonable procedures exist for resolving enrollee grievances as required by the Code; however, an HMO would be subject to the Code's internal grievance provisions that apply to insurers generally.

Basic Health Services. Under the Code, coinsurance for basic health services under an HMO contract, excluding deductibles, may not exceed 50% of the HMO's reimbursement to an affiliated provider for providing the service to an enrollee and may not be based on the provider's standard charge for the service. The bill would delete this provision.

The Code requires all HMO contracts to include, at a minimum, basic health services. Under the bill, instead, an HMO would have to offer basic health services to large employers in at least one HMO contract.

"Basic health services" currently means all of the following:

-- Physician services, including consultant and referral services by a physician, but not including psychiatric services.
-- Ambulatory services.
-- Inpatient hospital services, other than those for the treatment of mental illness.
-- Emergency health services.
-- A minimum of 20 visits per year for outpatient mental health services.
-- Intermediate and outpatient care for substance abuse, subject to certain conditions.
-- Diagnostic laboratory and diagnostic and therapeutic radiological services.
-- Home health services.
-- Preventive health services.

Under the bill, "basic health services" would mean medically necessary health services that HMOs must offer to large employers in at least one HMO contract. The term would include all of the following:

-- Physician services, including primary and specialty care.
-- Ambulatory services.
-- Inpatient hospital services.
-- Emergency health services.
-- Mental health and substance use disorder treatment.
-- Diagnostic laboratory and diagnostic and therapeutic radiological services.

-- Home health services.
-- Preventive health services.

HMO Provider Credentialing. The Code requires an HMO to establish written policies and procedures for credentialing verification of all health professionals with whom the HMO contracts and apply these standards consistently. The bill provides that the Code would not require an HMO to select a provider as an affiliated provider solely because the provider met the HMO's credentialing verification standards, and would not prevent an HMO from using separate or additional criteria in selecting the health professionals with whom it contraced.

The bill provides that an HMO would be considered to meet these requirements if it were accredited by a nationally recognized accredited body approved by the DIFS Director.

The bill would delete requirements that an HMO do the following:

-- Verify a health professional's credentials before entering into a contract with him or her.
-- Establish a credentialing verification committee to review credentialing information and supporting documents and make decisions regarding verification.
-- Make available for review by an applying health professional upon request all application and credentialing verification policies and procedures.
-- Retain all records and documents relating to a health professional's credentialing verification process for at least three years.
-- Keep confidential all information obtained in the credentialing verification process, except as otherwise provided by law.

The bill also would delete a requirement that an HMO obtain primary verification of specified information about an applicant to become a health professional with the HMO and require all participating providers to notify the HMO of changes in the status of any of the information at any time.

Prudent Purchaser Contracts. The bill would delete provisions that do the following:

-- Subject prudent purchaser contracts and the rates charged for them to the same regulatory requirements as HMO contracts.
-- Prohibit the rates under such contracts from being unreasonably lower than necessary to meet the expenses of the organization for providing the coverage and having an anticompetitive effect or resulting in predatory pricing in relation to prudent purchaser agreement coverage offered by other organizations.
-- Prohibit an HMO from issuing prudent purchaser contracts unless it is in full compliance with the requirements for adequate working capital, statutory deposits, and reserves and is not operating under any limitation to its authorization to do business in Michigan.
-- Require an HMO to maintain financial records for its prudent purchaser contracts and activities in a form separate or separable from the records of other operations and activities carried out by the HMO.

Noninsured Benefit Plan. The bill would allow an HMO to process and pay claims on behalf of a noninsured benefit plan only after the HMO had received adequate money from the plan sponsor to fully cover the claim payments. "Noninsured benefit plan" would mean a benefit plan without insurance or the noninsured portion of a benefit plan that has specific or aggregate excess loss insurance.

Insolvent HMO. Under the bill, notwithstanding any provision to the contrary, an enrollee of an insolvent HMO who was eligible to obtain coverage as either an individual or a member of a small group under an American health benefit exchange established or operating in Michigan

pursuant to the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, could obtain substitute coverage through the exchange.

Chapter 37: Small Employer Group Health Coverage

Under Chapter 37, "small employer" means any person actively engaged in business that, on at least 50% of its working days during the preceding and current calendar years, employed at least two and not more than 50 eligible employees.

For adjusting premiums for health benefit plans subject to Chapter 37, an insurance carrier may establish up to 10 geographic areas in the State. The bill would instead require a carrier to use the defined geographic areas established by the DIFS Director and allowed under Federal law.

Except as otherwise provided, a small employer carrier that offers health coverage in the small employer group market in connection with a health benefit plan must renew or continue in force the plan at the option of the small employer. Guaranteed renewal, however, is not required under any of the following circumstances:

-- There is fraud or intentional misrepresentation by the small employer.
-- For coverage of an insured individual, there is fraud or misrepresentation by the individual or his or her representative.
-- Lack of payment.
-- Noncompliance with minimum participation requirements.
-- The small employer carrier no longer offers that particular type of coverage in the market.
-- The small employer moves outside of the geographic area.

The bill would include noncompliance with minimum contribution requirements among the conditions under which the guaranteed renewal requirement does not apply.

The bill would allow a small employer carrier that offered health coverage in the small employer group market to modify a health benefit plan if the modification were consistent with State law and effective on a uniform basis among all small employers with coverage under the plan.

The bill would delete a number of provisions pertaining to sole proprietors, including one allowing a small employer carrier to charge a sole proprietor premiums that are 25% higher than the premiums that may be established based on rating factors prescribed in the Code.

Nonprofit Dental Care Corporation

The bill would include in the definition of "insurer" a nonprofit dental care corporation with regard to provisions related to the following:

-- The privileges associated with an insurance compliance self-evaluative audit document.
-- The confidentiality of certain records provided to the DIFS Director.
-- The trustworthiness of an insurer's officers and directors and removal of an officer or director whose continuation in that position the DIFS Director believes is hazardous or injurious to the insurer, policyholders, or the public.
-- A certificate of authority from the Director required for a person to act as an insurer and for an insurer to issue a policy or otherwise transact insurance in Michigan.
-- An insurer's reinsurance of any authorized risk and granting of reinsurance on any similar risk undertaken by another insurer.
-- An annual audited financial report that must be filed with the Director.

-- A prohibition against engaging in a trade practice that is an unfair method of competition or an unfair and deceptive act or practice in the business of insurance.
-- An insurer's internal grievance procedures by which an enrollee may appeal an adverse determination by the insurer.
-- Approval by the Director of insurance forms and delivery of an insurance form or required notice to a subscriber, insured, enrollee, or contract holder.
-- A prohibition against an insurer's use of a "most favored nation" clause in a provider contract.
-- The Director's disapproval of a policy form or rate.

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.

Fiscal Analyst: Josh Sefton

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.