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BILL ANALYSIS

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Senate Bills 631 and 673 (as enacted)

PUBLIC ACTS 222 & 223 of 2017

Sponsor: Senator Mike Shirkey (S.B. 631)
Senator Joe Hune (S.B. 673)
Senate Committee: Insurance
House Committee: Insurance

Date Completed: 1-3-18

RATIONALE

Public Act 125 of 1963 allows Michigan residents to form a nonprofit corporation for the purpose of establishing, maintaining, and operating nonprofit dental care plans by which professional dental services are provided at the expense of the corporation to people who become subscribers to the plans. The Act contains regulations for nonprofit dental care corporations, and includes provisions detailing the composition of a nonprofit dental care corporation's board of directors. In particular, the Act required a portion of the board members to be licensed dentists approved by the Michigan State Dental Association or its successor organization.

Evidently, there was a disagreement between Delta Dental of Michigan (the only nonprofit dental care corporation currently operating under the Act) and the Michigan Dental Association about certain aspects of the approval process by the Association. Some believed that statutory amendments should be enacted to clarify the process and resolve the issue between the organizations, as well as make the nonprofit dental corporation subject to certain requirements that apply to insurers.

CONTENT

Senate Bill 631 amended Public Act 125 of 1963 to do the following:

- **Delete a requirement that 40% to 60% of the board of directors of a dental care corporation be dentists approved by the Michigan Dental Association.**
- **Allow the Michigan Dental Association to submit to the corporation a list of recommended board candidates.**
- **Require at least 40% of the board members to be dentists who are not active employees of the dental care corporation.**
- **Require a minimum portion of those dentists to be members of the Michigan Dental Association at the time of appointment or reappointment to the board.**
- **Require the Director of the Department of Insurance and Financial Services to hold a hearing if he or she believes that the composition of the board is not in compliance with the bill, and order the corporation to comply if it is not in compliance.**
- **Require, on the Michigan Dental Association's request, not more than annually, the dental care corporation to provide certain board information.**

Senate Bill 673 amended the Insurance Code to do the following:

- **Remove an exclusion for a nonprofit dental care corporation from certain insurer requirements regarding the timely payment of claims, the payment of interest, processing and payment procedures, and other related matters.**

-- **Prohibit a nonprofit dental care corporation from requiring individuals to undergo genetic testing before issuing, renewing, or continuing a policy, or to disclose whether genetic testing had been conducted or genetic results or information.**
-- **Prohibit a nonprofit dental care corporation from requiring face-to-face contact between a health care professional and a patient for services provided through telemedicine.**

The bills took effect on December 20, 2017.

Senate Bill 631

Public Act 125 of 1963 requires the board of directors of a dental care corporation to consist of not more than 25 members. Previously, the board was required to have representation from the general public, and from among the various classes of subscribers enumerated in Section 19 and from the Michigan State Dental Association or its successor, but at least 40% and not more than 60% of the directors had to be licensed dentists who were approved by the Michigan State Dental Association or its successor.

(Section 19 of the Act states that a dental care corporation may receive from governmental or private agencies, corporations, associations, groups, or individuals, within or outside the State, payments covering all or part of the costs of subscriptions to provide dental care for needy and other people.)

Instead, the bill requires the board of directors of a dental care corporation to have representation from the general public, from licensed dentists, and from among the various classes of subscribers identified in Section 19. The Michigan Dental Association, or its successor, may submit to a dental care corporation a list of candidates recommended for appointment to the board. The corporation may consider those recommended candidates, but is not required to appoint any recommended candidate to the board.

Subject to the following requirements, not less than 40% of the directors of a dental care corporation must be licensed dentists who are not active employees of the corporation. Of those directors, a minimum portion must be members of the Michigan Dental Association at the time of appointment or reappointment to the board. At a minimum, the proportion must equal the percentage of licensed dentists who are also members of the Michigan Dental Association. The board may not consist of more than 60% licensed dentist directors.

If the Director of the Department of Insurance and Financial Services believes that the composition of the board is not in compliance with these provisions, he or she must hold a hearing. After the hearing and after written findings that the board composition does not comply with the requirements under the Act, the Director must issue and cause to be served on the dental care corporation a copy of the findings and an order requiring the corporation to comply. If the corporation does not comply with the order within 30 days, the Director may order the payment of a civil fine of up to $10,000.

Not more frequently than annually, a dental care corporation must provide all of the following information on the Michigan Dental Association's request:

-- The names of the dentist directors.
-- The terms of service of the dentist directors.
-- The date on which new dentist directors are elected.

Senate Bill 673

Benefit Payment Requirements

Under the Insurance Code, a person must pay on a timely basis to its insured, a person directly

entitled to benefits under its insured's insurance contract, or a third party tort claimant the benefits provided under the terms of its policy, or pay 12% interest on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims is an unfair trade practice unless the claim is reasonably in dispute.

An insurer must specify in writing the materials that constitute a satisfactory proof of loss within 30 days after receiving a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss is considered paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim is considered paid on a timely basis if paid within 60 days after the insurer's receipt of necessary medical information.

If benefits are not paid on a timely basis, the benefits bear interest as provided in the Code, and the interest must be paid as required by the Code.

If a person contracts to provide benefits and reinsures all or a portion of the risk, the person is liable for interest due to an insured, a person directly entitled to benefits under its insured's insurance contract, or a third party tort claimant if a reinsurer fails to pay benefits on a timely basis.

Each health professional, health facility, home health care provider, and durable medical equipment (DME) provider in billing for services rendered and each health plan in processing and paying claims for services rendered must use timely processing and payment procedures outlined under the Code.

If a health plan determines that one or more services listed on a claim are payable, the health plan must pay for those services and may not deny the entire claim because one or more other services listed on the claim are defective.

A health plan may not terminate the affiliation status or the participation of a health professional, health facility, home health care provider, or DME provider with a health maintenance organization provider panel or otherwise discriminate against a health professional, health facility, home health care provider, or DME provider because that entity claims that a health plan violated the provisions described above.

A health professional, health facility, home health care provider, DME provider, or health plan alleging that a timely processing or payment procedure under these provisions has been violated may file a complaint with the Director of the Department of Insurance and Financial Services and has a right to a determination of the matter by the Director or his or her designee.

In addition to any other penalty provided for by law, the Director may impose a civil fine of up to $1,000 for each violation not to exceed $10,000 in the aggregate for multiple violations.

Previously, the above provisions did not apply to a nonprofit dental care corporation operating under Public Act 125 of 1963. Under the bill, the provisions do apply to a dental care corporation after December 31, 2017.

<u>Genetic Testing & Telemedicine</u>

Under the Code, an insurer that delivers, issues for delivery, or renews in the State a health insurance policy may not require an insured or his or her dependent or an asymptomatic applicant for insurance or his or her asymptomatic dependent to do either of the following:

-- Undergo genetic testing before issuing, renewing, or continuing the policy in Michigan.

-- Disclose whether genetic testing has been conducted or the results of genetic testing or genetic information.

A health insurer also may not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the State where the patient is located. Telemedicine services are subject to all terms and conditions of the health insurance policy agreed upon between the policy holder and the insurer, including required copayments, coinsurances, deductibles, and approved amounts.

Regarding the provisions described above, the bill specifies that after December 31, 2017, "insurer" includes a nonprofit dental care corporation operating under Public Act 125 of 1963.

MCL 550.363 (S.B. 631)
500.2006 et al. (S.B. 673)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bills are the product of a compromise reached between Delta Dental and the Michigan Dental Association to resolve a dispute over the process by which the Association approved dentist board members. The agreement changes the way in which dentists are selected to serve on the corporation's board, but maintains the representation requirement for dentists who are members of the Association and requires the nonprofit dental care corporation to be subject to certain requirements under the Insurance Code regarding genetic testing, telemedicine, and payment procedures. The bills provide clarity to the board of directors selection process, enhance transparency, and promote future cooperation between the entities.

Legislative Analyst: Drew Krogulecki

FISCAL IMPACT

Senate Bill 631

The bill will have a minimal, negative impact on the Department of Insurance and Financial Services. The bill adds enforcement duties for the Director of the Department regarding the makeup of the board of a dental care corporation. The new duties require the Director to hold hearings, issue notices of findings, and order the payment of civil fines for a dental care corporation that is not in compliance with bill's requirements for board makeup. The increased costs associated with these duties will be minimal and are expected to be absorbed by the Department.

The bill will have no fiscal impact on local government.

Senate Bill 673

The bill will have no fiscal impact on State or local government.

Fiscal Analyst: Michael Siracuse

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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.