Act No. 472
Public Acts of 1996
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December 22, 1996
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STATE OF MICHIGAN
88TH LEGISLATURE
REGULAR SESSION OF 1996

Introduced by Reps. Crissman, Gubow, Horton, Profit, Dolan, Rocca, Kukuk, Baird, Jamian, Jellema, Goschka, Freeman, Harder, Gire, Curtis, DeHart, Pitoniak, Yokich, Weeks, LeTarte, Green, Hertel, Baade, Rhead, McManus, Fitzgerald, Alley, Schroer, Gustafson, Bankes, Cherry, Middleton, Bodem, Lowe, Wetters, Brater, Walberg, Galloway, Gernaat and Llewellyn
Reps. Agee, Anthony, Bennane, Berman, Brackenridge, Brewer, Bush, Byl, Ciaramitaro, Clack, Cropsey, Dalman, DeLange, DeMars, Dobb, Dobronski, Emerson, Gagliardi, Geiger, Gilmer, Gnodtke, Griffin, Hammerstrom, Hanley, Hill, Jersevic, Kelly, Kilpatrick, LaForge, London, Martinez, Mathieu, McBryde, McNutt, Middaugh, Murphy, Nye, Olshove, Owen, Oxender, Palamara, Parks, Perricone, Porreca, Price, Prusi, Randall, Ryan, Scott, Sikkema, Tesanovich, Varga, Vaughn, Voorhees, Wallace, Whyman and Willard named co-sponsors

ENROLLED HOUSE BILL No. 5573

AN ACT to amend section 21073 of Act No. 368 of the Public Acts of 1978, entitled as amended "An act to protect and promote the public health; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; to create or continue, and prescribe the powers and duties of, departments, boards, commissions, councils, committees, task forces, and other agencies; to prescribe the powers and duties of governmental entities and officials; to regulate occupations, facilities, and agencies affecting the public health; to regulate health maintenance organizations and certain third party administrators and insurers; to provide for the imposition of a regulatory fee; to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates," as amended by Act No. 354 of the Public Acts of 1982, being section 333.21073 of the Michigan Compiled Laws; to add sections 21035 and 21052; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

Section 1. Section 21073 of Act No. 368 of the Public Acts of 1978, as amended by Act No. 354 of the Public Acts of 1982, being section 333.21073 of the Michigan Compiled Laws, is amended and sections 21035 and 21052 are added to read as follows:

Sec. 21035. (1) By October 1, 1997, a health maintenance organization shall establish pursuant to section 21034(i) an internal formal enrollee grievance procedure for approval by the insurance bureau that includes all of the following:

(a) That when an adverse determination is made, a written statement containing the reasons for the adverse determination will be provided to an enrollee.

(b) That a written notification of the grievance procedures will be provided to an enrollee when the enrollee contests an adverse determination.

(c) That a final determination will be made in writing by the organization not later than 90 calendar days after a formal grievance is submitted by an enrollee. The timing for the 90-calendar-day period may be tolled, however, for any period of time the enrollee is permitted to take under the grievance procedure.

(d) That an initial determination will be made by the health maintenance organization not later than 72 hours after receipt of an expedited grievance. Within 3 business days after the initial determination by the health maintenance organization, the enrollee or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the enrollee may request further review by the health maintenance organization or the enrollee may appeal to the department. If further review is requested, a final determination by the health maintenance organization shall be made not later than 30 days after receipt of the request for further review. Within 10 days after receipt of a final determination, the enrollee or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the enrollee may appeal to the department. If the initial or final determination by the health maintenance organization is made orally, the health maintenance organization shall provide a written confirmation of the determination to the enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (c) would acutely jeopardize the life of the enrollee.

(e) That an enrollee has the right to a final appeal to the department.

(2) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(3) As used in this section:

(a) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

(b) "Grievance" means a complaint on behalf of an enrollee submitted by an enrollee or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the enrollee regarding:

(*i*) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(*ii*) Benefits or claims payment, handling, or reimbursement for health care services.

(*iii*) Matters pertaining to the contractual relationship between an enrollee and the organization.

Sec. 21052. (1) By October 1, 1997, a health maintenance organization shall provide a written form in plain English to subscribers upon enrollment that describes the terms and conditions of the organization's contract. The form shall provide a clear, complete, and accurate description of all of the following as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of enrollee financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment in the event a provider's participation terminates during the course of an enrollee's treatment by that provider.

(g) The telephone number to call to receive information concerning enrollee grievance procedures.

(h) A summary listing of the information available pursuant to subsection (2).

(2) By October 1, 1997, a health maintenance organization shall provide upon request to enrollees a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the contract's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new enrollees.

(b) The professional credentials of participating health professionals, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of affiliated licensed facilities where the health professional presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the Michigan department of consumer and industry services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(e) Indication of the financial relationships between the health maintenance organization and any closed provider panel including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the health maintenance organization additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) shall be provided in writing. A health maintenance organization may require that a request under subsection (2) be submitted in writing.

Sec. 21073. (1) For an individual covered under a nongroup contract or under a contract not covered under subsection (2), a health maintenance organization may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the health maintenance contract.

(2) A health maintenance organization shall not exclude or limit coverage for a preexisting condition for an individual covered under a group contract.

(3) The insurance commissioner and the director of community health shall examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by a preexisting condition limitation or exclusion under subsection (1) and shall report to the governor and the senate and the house of representatives standing committees on insurance and health policy issues by May 15, 1997. The report shall include the commissioner's and director's findings and shall propose alternative mechanisms or a combination of mechanisms to credit prior continuous health care coverage towards the period of time imposed by a preexisting condition limitation or exclusion. The report shall address at a minimum all of the following:

(a) Cost of crediting prior continuous health care coverages.

(b) Period of lapse or break in coverage, if any, permitted in a prior health care coverage.

(c) Types and scope of prior health care coverages that are permitted to be credited.

(d) Any exceptions or exclusions to crediting prior health care coverage.

(e) Uniform method of certifying periods of prior creditable coverage.

(4) Except as provided in subsection (6), a health maintenance organization that has issued a nongroup contract shall renew or continue in force the contract at the option of the individual.

(5) Except as provided in subsection (6), a health maintenance organization that has issued a group contract shall renew or continue in force the contract at the option of the sponsor of the plan.

(6) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health maintenance organization no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(7) As used in this section, "group" means a group of 2 or more subscribers.

Section 2. Section 21086 of Act No. 368 of the Public Acts of 1978, being section 333.21086 of the Michigan Compiled Laws, is repealed effective October 1, 1997.

Section 3. This amendatory act shall take effect October 1, 1997.

This act is ordered to take immediate effect.

Clerk of the House of Representatives.

Secretary of the Senate.

Approved _____

Governor.