HOUSE BILL No. 4991

June 26, 1997, Introduced by Reps. Palamara and Profit and referred to the Committee on Insurance.

A bill to amend 1980 PA 350, entitled

"The nonprofit health care corporation reform act,"

by amending section 401 (MCL 550.1401), as amended by 1984 PA 66.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 401. (1) A health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the corporation specifies with the approval of the commissioner.

(2) A health care corporation may limit the health care benefits that it will furnish, except as provided in this act, and may divide the health care benefits ~~which~~ THAT it elects to furnish into classes or kinds.

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(3) A health care corporation shall not do any of the following:

(a) Refuse to issue or continue a certificate to 1 or more residents of this state, except while the individual, based on a transaction or occurrence involving a health care corporation, is serving a sentence arising out of a charge of fraud, is satisfying a civil judgment, or is making restitution pursuant to a voluntary payment agreement between the corporation and the individual.

(b) Refuse to continue in effect a certificate with 1 or more residents of this state, other than for failure to pay amounts due for a certificate, except as allowed for refusal to issue a certificate under subdivision (a).

(c) Limit the coverage available under a certificate, without the prior approval of the commissioner, unless the limitation is as a result of: an agreement with the person paying for the coverage; an agreement with the individual designated by the persons paying for or contracting for the coverage; or a collective bargaining agreement.

(D) CANCEL BENEFITS ON, REFUSE TO PROVIDE BENEFITS FOR, OR REFUSE TO ISSUE OR CONTINUE A CERTIFICATE FOR A SUBSCRIBER OR APPLICANT SOLELY BECAUSE OF THE GENETIC INFORMATION OF THAT SUBSCRIBER OR APPLICANT. AS USED IN THIS SUBDIVISION, "GENETIC INFORMATION" MEANS ANY INFORMATION ABOUT AN INDIVIDUAL THAT IS DERIVED FROM THE PRESENCE, ABSENCE, ALTERATION, OR MUTATION OF A GENE OR GENES, OR THE PRESENCE OR ABSENCE OF A SPECIFIC DNA MARKER OR MARKERS, AND THAT HAS BEEN OBTAINED EITHER FROM AN

ANALYSIS OF THE INDIVIDUAL'S DNA OR FROM AN ANALYSIS OF THE DNA OF A PERSON TO WHOM THE INDIVIDUAL IS RELATED.

(4) ~~Nothing in subsection (3) shall~~ SUBSECTION (3) DOES NOT prevent a health care corporation from denying to a resident of this state coverage under a certificate for any of the following grounds:

(a) That the individual was not a member of a group ~~which~~ THAT had contracted for coverage under this certificate.

(b) That the individual is not a member of a group with a size greater than a minimum size established for a certificate pursuant to sound underwriting requirements.

(c) That the individual does not meet requirements for coverage contained in a certificate.

(5) A certificate may provide for the coordination of benefits, subrogation, and the nonduplication of benefits. Savings realized by the coordination of benefits, subrogation, and nonduplication of benefits shall be reflected in the rates for those certificates. If a group certificate issued by the corporation contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act, 1984 PA 64, MCL 550.251 TO 550.255.

(6) A health care corporation shall have the right to status as a party in interest, whether by intervention or otherwise, in any judicial, quasi-judicial, or administrative agency proceeding in this state for the purpose of enforcing any rights it may have for reimbursement of payments made or advanced for health care services on behalf of 1 or more of its subscribers or members.

(7) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

(8) A health care corporation shall not limit or deny coverage to a subscriber or limit or deny reimbursement to a provider on the ground that services were rendered while the subscriber was in a health care facility operated by this state or a political subdivision of this state. A health care corporation shall not limit or deny participation status to a health care facility on the ground that the health care facility is operated by this state or a political subdivision of this state, if the facility meets the standards set by the corporation for all other facilities of that type, government-operated or otherwise. To qualify for participation and reimbursement, a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

(a) Be accredited by the joint commission on accreditation of hospitals.

(b) Meet the certification standards of the medicare program and the medicaid program.

(c) Meet all statutory requirements for certificate of need.

(d) Follow generally accepted accounting principles and practices.

(e) Have a community advisory board.

(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

(g) Designate that portion of the facility ~~which~~ THAT is to be used for acute care.