

THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT (EXCERPT)
Act 350 of 1980

550.1467 Medicare select certificate.

Sec. 467. (1) This section applies to medicare select certificates.

(2) As used in this section:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select health care corporation or its network providers.

(b) "Grievance" means a dissatisfaction expressed in writing by an individual covered under a medicare select certificate with the administration, claims practices, or provision of services concerning a medicare select health care corporation or its network providers.

(c) "Medicare select health care corporation" means a health care corporation offering, or seeking to offer, a medicare select certificate.

(d) "Medicare select certificate" means a medicare supplement certificate that contains restricted network provisions.

(e) "Network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the health care corporation to provide benefits under a medicare select certificate.

(f) "Restricted network provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(g) "Service area" means the geographic area approved by the commissioner within which a health care corporation is authorized to offer a medicare select certificate.

(3) A certificate shall not be advertised as a medicare select certificate unless it meets the requirements of this section.

(4) The commissioner may authorize a health care corporation to offer a medicare select certificate, pursuant to this section and section 1882 of part C of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395ss, if the commissioner finds that the health care corporation has satisfied all necessary requirements.

(5) A medicare select health care corporation shall not issue a medicare select certificate in this state until its plan of operation has been approved by the commissioner.

(6) A medicare select health care corporation shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, as follows:

(i) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(ii) That the number of network providers in the service area is sufficient, with respect to current and expected certificate holders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

(iii) That there are written agreements with network providers describing specific responsibilities.

(iv) That emergency care is available 24 hours per day and 7 days per week.

(v) That in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual covered under a medicare select certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the medicare select certificate.

(b) A statement or map providing a clear description of the service area.

(c) A description of the grievance procedure to be used.

(d) A description of the quality assurance program, including all of the following:

(i) The formal organizational structure.

(ii) The written criteria for selection, retention, and removal of network providers.

(iii) The procedures for evaluating quality of care provided by network providers and the process to initiate corrective action if warranted.

(e) A list and description, by specialty, of the network providers.

(f) Copies of the written information proposed to be used by the health care corporation to comply with subsection (10).

(g) Any other information requested by the commissioner.

(7) A medicare select health care corporation shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing any changes. An updated list of network providers shall be filed with the commissioner at least quarterly. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

(8) A medicare select certificate shall not restrict payment for covered services provided by nonnetwork providers if the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition and it is not reasonable to obtain such services through a network provider.

(9) A medicare select certificate shall provide payment for full coverage under the certificate for covered services that are not available through network providers.

(10) A medicare select health care corporation shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select certificate to each applicant. This disclosure shall include at least all of the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select certificate with other medicare supplement certificates offered by the health care corporation or offered by other health care corporations.

(b) A description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles if providers other than network providers are utilized.

(d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(e) A description of limitations on referrals to restricted network providers and to other providers.

(f) A description of the certificate holder's rights to purchase any other medicare supplement certificate otherwise offered by the health care corporation.

(g) A description of the medicare select health care corporation's quality assurance program and grievance procedure.

(11) Prior to the sale of a medicare select certificate, a medicare select health care corporation shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (10) and that the applicant understands the restrictions of the medicare select certificate.

(12) A medicare select health care corporation shall have and use procedures for hearing complaints and resolving written grievances from subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. The grievance procedure shall be described in the certificate and in the outline of coverage. At the time the certificate is issued, the health care corporation shall provide detailed information to the certificate holder describing how a grievance may be registered with the health care corporation. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action. If a grievance is found to be valid, corrective action shall be taken promptly. All concerned parties shall be notified about the results of a grievance. The health care corporation shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.

(13) At the time of initial purchase, a medicare select health care corporation shall make available to each applicant for a medicare select certificate the opportunity to purchase any medicare supplement certificate otherwise offered by the health care corporation.

(14) At the request of an individual covered under a medicare select certificate, a medicare select health care corporation shall make available to the individual covered the opportunity to purchase a medicare supplement certificate offered by the health care corporation that has comparable or lesser benefits and that does not contain a restricted network provision. The health care corporation shall make the certificates available without requiring evidence of insurability after the medicare supplement certificate has been in force for 6 months. For the purposes of this subsection, a medicare supplement certificate shall be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for outpatient prescription drugs, coverage for at-home

recovery services, or coverage for part B excess charges.

(15) Medicare select certificates shall provide for continuation of coverage if the secretary of health and human services determines that medicare select certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment. Each medicare select health care corporation shall make available to each member covered under a medicare select certificate the opportunity to purchase any medicare supplement certificate offered by the health care corporation that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the certificates available without requiring evidence of insurability. For the purposes of this subsection, a medicare supplement certificate will be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery service, or coverage for part B excess charges.

(16) A medicare select health care corporation shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purposes of evaluating the medicare select program.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350