HOUSE BILL No. 4791

May 18, 1993, Introduced by Reps. Berman, Pitoniak, Martin and Brown and referred to the Committee on Insurance.

A bill to amend sections 402 and 407 of Act No. 350 of the Public Acts of 1980, entitled as amended "The nonprofit health care corporation reform act," as amended by Act No. 132 of the Public Acts of 1989, being sections 550.1402 and 550.1407 of the Michigan Compiled Laws; and to add section 416b.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 402 and 407 of Act No. 350 of the Public Acts of 1980, as amended by Act No. 132 of the Public Acts of 1989, being sections 550.1402 and 550.1407 of the Michigan Compiled Laws, are amended and section 416b is added to read as follows:

Sec. 402. (1) A health care corporation shall not do any of the following:

(a) Misrepresent pertinent facts or certificate provisions relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within ~~a reasonable time~~ 60 DAYS after ~~a claim has been~~ THE HEALTH CARE CORPORATION HAS received A COMPLETED WRITTEN CLAIM.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

(g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.

(h) By making reference to written or printed advertising material accompanying or made part of an application for coverage, attempt to settle a claim for less than the amount which a reasonable person would believe was due under the certificate.

(i) For the purpose of compelling a member to accept a settlement or compromise in a claim, make known to the member a policy of appealing from administrative hearing decisions in favor of members.

(j) Attempt to settle a claim on the basis of an application which was altered without notice to, or knowledge or consent of, the subscriber under whose certificate the claim is being made.

(k) Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(l) Fail to ~~promptly~~ provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement WITHIN 60 DAYS AFTER RECEIPT OF A COMPLETED WRITTEN CLAIM.

(m) Fail to ~~promptly~~ IMMEDIATELY settle a claim ~~where liability has become reasonably clear~~ FOR WHICH THE HEALTH CARE CORPORATION'S LIABILITY under 1 portion of a certificate IS REASONABLY CLEAR in order to influence a settlement under another portion of the certificate.

(2) ~~In order to~~ TO induce a person to contract or to continue to contract with the health care corporation for the provision of health care benefits or administrative or other services offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate issued by the health care corporation; or to induce a person to secure or terminate coverage with another health care corporation, insurer, health maintenance organization, or other person, a health care corporation shall not, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or part of the premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, ~~any~~ AN estimate, illustration, circular, or statement misrepresenting the terms OR BENEFITS of a certificate or contract for administrative or other services, ~~the benefits thereunder,~~ or the true nature ~~thereof~~ OF THAT CERTIFICATE OR CONTRACT.

(e) Make ~~a~~ AN ORAL OR WRITTEN misrepresentation or incomplete comparison ~~, whether oral or written,~~ between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization, or other person.

(3) A health care corporation shall not provide a commission or other compensation to the health care corporation's agent or employee for the sale or service of a health care benefits certificate issued to an individual eligible for medicare, unless the amount of the commission or compensation paid in the first year of the certificate is not more than the amount of the commission or compensation that the health care corporation's

agent or employee receives for the certificate in each of the 2 subsequent, consecutive annual renewal periods.

(4) A health care corporation shall not issue a certificate to an individual eligible for medicare that provides for a new preexisting condition limitation waiting period if coverage is converted to or replaced by a new or other form of similar coverage with the same health care corporation or any of the health care corporation's affiliates. If the preexisting condition limitation waiting period in the original or replaced certificate has not expired, the replacing certificate may include the remaining term of the preexisting condition limitation waiting period of the replaced certificate. This subsection does not apply to an increase in benefits voluntarily selected by the individual.

(5) Nothing in subsection (2) ~~shall prevent~~ PREVENTS a health care corporation from readjusting the rates charged to a subscriber group which is experience-rated based on the previous claims of the group.

(6) The commissioner shall allow a health care corporation to participate in ~~any~~ A trade practice conference for disability insurers convened under section 2047 of THE INSURANCE CODE OF 1956, Act No. 218 of the Public Acts of 1956, being section 500.2047 of the Michigan Compiled Laws, and may bind a health care corporation to any rules promulgated as provided in that section.

(7) Nothing in this section shall alter or supersede any provider class plan established pursuant to part 5.

(8) If the commissioner has probable cause to believe that a health care corporation ~~is violating, or has violated subsection (1), indicating~~ HAS a persistent tendency to engage in conduct prohibited by ~~that subsection, or has probable cause to believe that a health care corporation is violating, or has violated subsection (2), (3), or (4), he or she shall give written notice to the corporation, pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the~~ SUBSECTION (1), (2), (3), OR (4), HE OR SHE SHALL NOTIFY THE HEALTH CARE CORPORATION OF THE SPECIFIC PROHIBITED CONDUCT FOR WHICH THE PROBABLE CAUSE EXISTS, AND ALLOW THE HEALTH CARE CORPORATION 30 DAYS TO ESTABLISH TO THE COMMISSIONER'S SATISFACTION THAT THE HEALTH CARE CORPORATION IS IN COMPLIANCE WITH SUBSECTION (1). IN ADDITION, THE COMMISSIONER SHALL DO EACH OF THE FOLLOWING:

(A) ENSURE THAT THE HEALTH CARE corporation HAS an opportunity to ~~confer and~~ PARTICIPATE IN AN IMMEDIATE INFORMAL CONFERENCE TO discuss ~~the possible complaint and proceedings~~ in person with the commissioner or a representative of the commissioner ~~, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to~~

THE COMPLAINT THAT MAY BE INSTITUTED AGAINST THAT HEALTH CARE CORPORATION AS A RESULT OF THE ALLEGED PROHIBITED CONDUCT.

(B) SUMMARILY RESOLVE ISSUES ADDRESSED AT THE INFORMAL CONFERENCE DESCRIBED IN SUBDIVISION (A) UPON AGREEMENT OF THE PARTIES.

(9) IF A HEALTH CARE CORPORATION FAILS TO PARTICIPATE IN AN INFORMAL CONFERENCE DESCRIBED IN SUBSECTION (8), OR IF AN ISSUE ADDRESSED AT THAT INFORMAL CONFERENCE IS NOT RESOLVED TO THE COMMISSIONER'S SATISFACTION AT THE TIME OF THE INFORMAL CONFERENCE, THE COMMISSIONER SHALL PROVIDE THE HEALTH CARE CORPORATION WITH A WRITTEN NOTICE OF A HEARING TO BE HELD NO LATER THAN 30 BUSINESS DAYS AFTER THE SCHEDULED DATE OF THE INFORMAL CONFERENCE. THE NOTICE SHALL COMPLY WITH THE ADMINISTRATIVE PROCEDURES ACT AND SHALL IDENTIFY BOTH OF THE FOLLOWING:

(A) THE CONDUCT OF THE HEALTH CARE CORPORATION ALLEGED TO BE PROHIBITED UNDER THIS SECTION.

(B) THE ACTION PROPOSED BY THE COMMISSIONER IN RESPONSE TO THE CONDUCT IDENTIFIED PURSUANT TO SUBDIVISION (A).

(10) SUBSECTIONS (8) AND (9) DO NOT diminish the right of a person to bring an action for damages under this section.

(11) ~~(9)~~ A hearing ~~held pursuant to~~ DESCRIBED IN subsection ~~(8)~~ (9) shall be held in accordance with ~~section 2030 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, as amended, being section 500.2030 of the Michigan Compiled Laws. The hearing shall be held pursuant to~~ the administrative procedures act. ~~of 1969, Act No. 306 of the Public Acts of 1969.~~

(12) WITHIN 20 BUSINESS DAYS AFTER THE HEARING DESCRIBED IN SUBSECTION (9), THE COMMISSIONER SHALL ISSUE AND SERVE UPON THE HEALTH CARE CORPORATION AND MAKE AVAILABLE TO THOSE PERSONS WHO APPEARED AT THE HEARING A WRITTEN STATEMENT OF THE COMMISSIONER'S FINDINGS. If ~~, after the hearing,~~ the commissioner determines BY A PREPONDERANCE OF THE EVIDENCE that the health care corporation ~~is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or is violating, or has violated subsection (2), (3), or (4), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and~~ HAS A PERSISTENT TENDENCY TO ENGAGE IN CONDUCT PROHIBITED BY SUBSECTION (1), (2), (3), OR (4), THE COMMISSIONER SHALL INCLUDE WITH HIS OR HER WRITTEN STATEMENT OF FINDINGS an order requiring the corporation to cease and desist from engaging in the prohibited activity. The commissioner may ~~at any time, by~~ ISSUE AN order ~~, and after notice and opportunity for a hearing,~~ TO reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, ~~when in his or her opinion conditions~~ IF HE OR SHE DETERMINES THAT THE PUBLIC INTEREST OR A CHANGE of fact or law ~~have so changed as to require~~ REQUIRES that action. ~~, or if the public interest so requires.~~

(13) ~~(10)~~ A health care corporation ~~which~~ THAT violates a cease and desist order ~~of the commissioner~~ issued under subsection ~~(9)~~ (12) OR FAILS TO COMPLY WITH THAT ORDER EITHER WITHIN 60 DAYS AFTER BEING SERVED WITH THE ORDER, OR WITHIN A

GREATER PERIOD OF TIME DETERMINED BY THE COMMISSIONER, IS SUBJECT TO A CIVIL FINE OF NOT MORE THAN $10,000.00 FOR EACH VIOLATION, after notice and an opportunity for a hearing, and upon order of the commissioner. ~~, may be subject to a civil fine of not more than $10,000.00 for each violation.~~

(14) ~~(11)~~ In addition to other remedies provided by law, an aggrieved member may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits AND SUBJECT TO SUBSECTION (15), the member shall be awarded actual monetary damages or $200.00, whichever is greater, together with reasonable attorneys' fees.

(15) If the health care corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery ~~shall be~~ IS limited to actual monetary damages.

(16) AS USED IN THIS SECTION, "BUSINESS DAY" MEANS A DAY OF THE YEAR THAT IS NOT A SATURDAY, SUNDAY, OR LEGAL HOLIDAY.

Sec. 407. (1) A health care corporation shall establish and maintain a complaint system ~~which~~ THAT affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by members concerning any matter relating to the provisions of a certificate. At a minimum, procedures shall be developed by a corporation for the resolution of claims for reimbursement; denial, cancellations, or nonrenewals of certificates; and complaints regarding the quality of the services

delivered by health care providers and health care facilities ~~which~~ THAT receive reimbursement from the corporation.

(2) A health care corporation, within 30 days after receipt of written complaint, shall give a reasonable written response to each written complaint ~~which~~ THAT it receives. The commissioner shall have free access, as defined in section 603(2), to complaints and responses, which shall be made available to the commissioner for inspection. If the matter complained of is reasonably believed by the complainant to be a violation of section 402 or 403, the complainant shall be entitled to a private informal managerial-level conference with the health care corporation, as provided for in section 404.

(3) The health care corporation shall maintain a complete record of all of the written complaints of its members ~~which~~ THAT the corporation has received since the date of the last examination. This record shall indicate the total number of complaints, ~~,~~ and by line of business, the nature of each complaint, the disposition of each complaint, and the time taken to process each complaint.

(4) ~~A~~ BY JUNE 1 OF EACH YEAR, A health care corporation shall submit to the commissioner AND TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON INSURANCE ISSUES an annual report ~~which~~ THAT describes the complaint system of the corporation, and includes a compilation and analysis of the written complaints filed with the corporation, their disposition and underlying causes, and measures being implemented to alleviate those causes. THE REPORT SHALL INCLUDE THE PREVIOUS 2-YEAR

TOTALS FOR EACH CATEGORY. The report shall be compiled in a manner ~~which~~ THAT protects an individual's right to privacy with respect to medical information and shall not disclose the identity of a member by name or other personal identifier without the member's consent pursuant to section 406(1). The annual report shall be a public record.

(5) This section shall not prevent a member from seeking other remedies available by law.

SEC. 416B. (1) THE ONCOLOGY ADVISORY PANEL IS CREATED WITHIN THE DEPARTMENT OF COMMERCE AND SHALL CONSIST OF 3 MEMBERS APPOINTED BY THE COMMISSIONER FROM A LIST OF PERSONS RECOMMENDED BY A HEALTH CARE CORPORATION AND THE ORGANIZATION DESCRIBED IN SUBDIVISION (A). THE APPOINTED PERSONS SHALL BE EACH OF THE FOLLOWING:

(A) MEMBERS OF A HEMATOLOGY AND ONCOLOGY ORGANIZATION WITHIN THIS STATE.

(B) MEMBERS, IDENTIFIED BY THE ORGANIZATION DESCRIBED IN SUBDIVISION (A), AS QUALIFIED TO ADVISE HEALTH CARE CORPORATIONS ABOUT THE EFFICACY, APPROPRIATENESS, AND ADMINISTRATION OF OFF-LABEL INDICATIONS OF FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED DRUGS USED IN ANTINEOPLASTIC THERAPY.

(2) THE COMMISSIONER SHALL APPOINT EACH MEMBER OF THE ONCOLOGY ADVISORY PANEL WITHIN 90 DAYS AFTER THE EFFECTIVE DATE OF THIS SECTION. EACH MEMBER SHALL SERVE FOR A TERM OF 5 YEARS, EXCEPT THAT OF THE MEMBERS FIRST APPOINTED, 1 SHALL BE APPOINTED FOR A TERM OF 3 YEARS, 1 SHALL BE APPOINTED FOR A TERM OF 4 YEARS, AND 1 SHALL BE APPOINTED FOR A TERM OF 5 YEARS.

(3) IF A VACANCY OCCURS ON THE ONCOLOGY ADVISORY PANEL, THE COMMISSIONER SHALL MAKE AN APPOINTMENT TO FILL THE VACANCY FOR THE BALANCE OF THE UNEXPIRED TERM IN THE SAME MANNER AS THE ORIGINAL APPOINTMENT.

(4) MEMBERS OF THE ONCOLOGY REVIEW PANEL SHALL SERVE WITHOUT COMPENSATION. HOWEVER, MEMBERS OF THAT PANEL MAY BE REIMBURSED FOR ACTUAL AND NECESSARY EXPENSES THEY MAY HAVE INCURRED IN THE PERFORMANCE OF THEIR OFFICIAL DUTIES AS MEMBERS OF THAT PANEL PURSUANT TO THE STANDARD TRAVEL REGULATIONS OF THE DEPARTMENT OF MANAGEMENT AND BUDGET.

(5) THE ONCOLOGY REVIEW PANEL SHALL ADVISE HEALTH CARE CORPORATIONS ABOUT THE EFFICACY, APPROPRIATENESS, AND ADMINISTRATION OF OFF-LABEL INDICATIONS OF FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED DRUGS USED IN ANTINEOPLASTIC THERAPY. WITHIN 2 YEARS AFTER THE EFFECTIVE DATE OF THIS SECTION, THE ONCOLOGY REVIEW PANEL SHALL SUBMIT TO THE COMMISSIONER AND TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON INSURANCE ISSUES A REPORT OF ITS RECOMMENDATIONS ON THE EFFICACY, APPROPRIATENESS, AND ADMINISTRATION OF OFF-LABEL INDICATIONS OF FEDERAL FOOD AND DRUG ADMINISTRATION APPROVED DRUGS USED IN ANTINEOPLASTIC THERAPY.

(6) WITHIN 60 DAYS AFTER THE HEALTH CARE CORPORATION ACCEPTS APPROVED DRUG INDICATIONS RECOMMENDED BY THE ONCOLOGY REVIEW PANEL, THE HEALTH CARE CORPORATION SHALL MAKE THE COMPUTER PROGRAMMING CHANGES NECESSARY TO ADD THOSE APPROVED DRUG INDICATIONS TO THOSE ALREADY COVERED BY THE HEALTH CARE CORPORATION. THE HEALTH CARE CORPORATION SHALL PUBLISH ITS ACCEPTANCE OF NEW DRUG

INDICATIONS IN THE FIRST PUBLICATION OF THE HEALTH CARE CORPORATION RECORD ISSUED WITHIN 90 DAYS AFTER ITS ACCEPTANCE OF THE NEW DRUG INDICATIONS.