HOUSE BILL No. 5573

February 13, 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 and referred to the Committee on Health Policy.

A bill to amend sections 21004 and 21073 of Act No. 368 of the Public Acts of 1978, entitled as amended

"Public health code,"

as amended by Act No. 354 of the Public Acts of 1982, being sections 333.21004 and 333.21073 of the Michigan Compiled Laws; and to add sections 21052, 21078, and 21079.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 21004 and 21073 of Act No. 368 of the Public Acts of 1978, as amended by Act No. 354 of the Public Acts of 1982, being sections 333.21004 and 333.21073 of the Michigan Compiled Laws, are amended and sections 21052, 21078, and 21079 are added to read as follows:

Sec. 21004. (1) "EMERGENCY HEALTH SERVICES" MEANS HEALTH CARE SERVICES PROVIDED TO EVALUATE AND TREAT MEDICAL CONDITIONS OF RECENT ONSET AND SEVERITY THAT WOULD LEAD A PRUDENT LAYPERSON,

POSSESSING AN AVERAGE KNOWLEDGE OF MEDICINE AND HEALTH, TO BELIEVE THAT URGENT OR UNSCHEDULED MEDICAL CARE IS REQUIRED.

(2) "Enrollee" means an individual who is entitled to receive health maintenance services under a health maintenance contract.

SEC. 21052. (1) BY OCTOBER 1, 1996, THE DIRECTOR SHALL CONSULT WITH THE COMMISSIONER TO ESTABLISH A STANDARD WRITTEN FORM THAT HEALTH MAINTENANCE ORGANIZATIONS SHALL USE TO DESCRIBE THE ORGANIZATION'S CONTRACT TERMS AND CONDITIONS. THE FORM SHALL BE IN PLAIN ENGLISH AND SHALL BE DESIGNED SO THAT LAYPERSONS CAN EASILY MAKE COMPARISONS AND INFORMED DECISIONS BEFORE SELECTING AMONG HEALTH CARE PLANS. THE FORM SHALL REQUIRE THE ORGANIZATION TO PROVIDE A CLEAR, COMPLETE, AND ACCURATE DESCRIPTION OF ALL OF THE FOLLOWING:

(A) THE CURRENT PROVIDER NETWORK, INCLUDING NAMES AND LOCATIONS OF IN-PANEL PROVIDERS, A STATEMENT OF LIMITATIONS OF ACCESSIBILITY AND REFERRALS TO SPECIALISTS, AND A DISCLOSURE OF WHICH IN-PANEL PROVIDERS WILL NOT ACCEPT NEW ENROLLEES OR PARTICIPATE IN CLOSED PROVIDER NETWORKS SERVING ONLY CERTAIN ENROLLEES.

(B) THE PROFESSIONAL CREDENTIALS OF ALL IN-PANEL SPECIALISTS, INCLUDING TYPE OF BOARD CERTIFICATION AND TYPE OF SPECIALIZATION; EXTENT OF EXPERIENCE, INCLUDING YEARS IN PRACTICE, TYPE OF PRACTICE, AND FACILITIES IN WHICH THE PROVIDER HAS PRACTICED, IF APPLICABLE; NATURE AND TYPE OF TRAINING THAT THE PROVIDER HAS COMPLETED; EXTRAORDINARY TRAINING; PARTICULAR EXPERTISE WITHIN A PROVIDER SPECIALTY; DISCIPLINARY ACTIONS THAT HAVE BEEN TAKEN AGAINST THE PROVIDER; LIMITATIONS OR RESTRICTIONS THAT HAVE BEEN

PLACED ON THE PROVIDER'S PRACTICE; AND LENGTH OF TIME AS AN IN-PANEL PROVIDER.

(C) THE SERVICE AREA.

(D) COVERED BENEFITS, INCLUDING PRESCRIPTION DRUG COVERAGE, WITH SPECIFICATIONS REGARDING REQUIREMENTS FOR THE USE OF GENERIC DRUGS.

(E) EMERGENCY CARE COVERAGE.

(F) OUT-OF-AREA COVERAGES AND BENEFITS.

(G) ANY LIMITATIONS, RESTRICTIONS, EXCLUSIONS, OR PRIOR AUTHORIZATION REQUIREMENTS 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.

(H) AN EXPLANATION OF ENROLLEE FINANCIAL RESPONSIBILITY FOR COPAYMENTS, DEDUCTIBLES, AND ANY OTHER OUT-OF-POCKET EXPENSES FOR NONCOVERED OR OUT-OF-PLAN SERVICES.

(I) PROVISION FOR CONTINUITY OF TREATMENT IN THE EVENT OF THE TERMINATION OF AN IN-PANEL PHYSICIAN.

(J) ANY PRIOR AUTHORIZATION REQUIREMENT, INCLUDING PROCEDURES FOR AND LIMITATIONS OR RESTRICTIONS ON REFERRALS TO PROVIDERS OTHER THAN PRIMARY CARE PHYSICIANS, OR OTHER REVIEW REQUIREMENTS, INCLUDING PRIOR AUTHORIZATION REVIEW, CONCURRENT REVIEW, POSTSERVICE REVIEW, AND POSTPAYMENT REVIEW, AND THE CONSEQUENCES OF FAILING TO OBTAIN ANY REQUIRED AUTHORIZATIONS.

(K) THE SIGNIFICANT GENERAL TERMS OF THE FINANCIAL RELATIONSHIPS BETWEEN THE HEALTH MAINTENANCE ORGANIZATION AND ITS

IN-PANEL PROVIDERS, FACILITIES, OR OTHER ENTITIES, INCLUDING ANY AGREEMENTS OR ARRANGEMENTS OR OWNERSHIP RELATIONSHIPS.

(*l*) A TELEPHONE NUMBER AND ADDRESS FOR THE PROSPECTIVE ENROLLEE TO OBTAIN ADDITIONAL INFORMATION CONCERNING THE ITEMS DESCRIBED IN SUBDIVISIONS (A) TO (K).

(2) BEGINNING JANUARY 1, 1997, A HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE TO PROSPECTIVE ENROLLEES AND FILE ANNUALLY WITH THE COMMISSIONER A COMPLETED COPY OF THE WRITTEN DESCRIPTION DESCRIBED IN SUBSECTION (1).

Sec. 21073. ~~A~~ FOR AN INDIVIDUAL COVERED UNDER A NONGROUP CONTRACT, A health maintenance organization may exclude coverage ~~for a condition for an individual covered under a nongroup contract, with~~ FOR a preexisting condition ~~which~~ THAT required active medical treatment during 6 months before enrollment BUT COVERAGE SHALL NOT BE EXCLUDED for ~~not~~ more than 6 months after the effective date of the health maintenance contract. EXCEPT AS OTHERWISE PROVIDED FOR MATERNITY CARE AND OBSTETRICAL SERVICE, A HEALTH MAINTENANCE ORGANIZATION SHALL NOT EXCLUDE COVERAGE FOR A PREEXISTING CONDITION FOR AN INDIVIDUAL COVERED UNDER A GROUP CONTRACT. Coverage under a nongroup OR GROUP contract for maternity care and obstetrical service related to a pregnancy that started before enrollment may be excluded for up to 9 months. Coverage for maternity care and obstetrical services shall be provided for any enrollee whose pregnancy starts after enrollment.

SEC. 21078. A HEALTH MAINTENANCE ORGANIZATION THAT, AGAINST THE ADVICE AND JUDGMENT OF THE TREATING PHYSICIAN, LIMITS OR

RESTRICTS A COVERED SERVICE OR A COURSE OF TREATMENT THAT FALLS WITHIN ITS CONTRACT BENEFITS OR COVERAGES AND EITHER ALTERS THE COURSE OF MEDICAL TREATMENT OR DENIES ACCESS TO SERVICES OR CONTINUED TREATMENT SHALL INDEMNIFY ANY TREATING HEALTH CARE PROVIDERS WHO SUBSEQUENTLY BECOME LIABLE TO THE ENROLLEE FOR DAMAGES CAUSED BY THE LIMITATION OR RESTRICTION FOR THE FULL EXTENT OF EACH PROVIDER'S LIABILITY FOR MONETARY DAMAGES.

SEC. 21079. (1) A HEALTH MAINTENANCE ORGANIZATION SHALL NOT USE FINANCIAL INCENTIVES TO ENCOURAGE A HEALTH CARE PROVIDER TO REFER AN ENROLLEE TO ANOTHER HEALTH CARE PROVIDER AND SHALL NOT USE FINANCIAL INCENTIVES TO DISCOURAGE A HEALTH CARE PROVIDER FROM REFERRING AN ENROLLEE TO ANOTHER HEALTH CARE PROVIDER.

(2) A HEALTH MAINTENANCE ORGANIZATION SHALL REIMBURSE ALL PROVIDERS, REGARDLESS OF SETTING OR PROVIDER RELATIONSHIPS, THE SAME AMOUNT FOR ANY GIVEN MEDICAL SERVICE.

(3) IF A HEALTH MAINTENANCE ORGANIZATION USES A MEDICAL FEE SCHEDULE TO DETERMINE PROVIDER REIMBURSEMENT, THE SCHEDULE SHALL BE BASED UPON REASONABLE AND CUSTOMARY CHARGES FOR THE GEOGRAPHIC AREA IN WHICH IT IS APPLIED.

(4) AS USED IN THIS SECTION:

(A) "IN-PANEL" PROVIDERS ARE THOSE MEDICAL PROVIDERS WHO ARE INCLUDED IN THE HEALTH MAINTENANCE ORGANIZATION'S PROVIDER NETWORK AND HAVE ENTERED INTO A CONTRACTUAL AGREEMENT WITH THE HEALTH MAINTENANCE ORGANIZATION TO PROVIDE CARE FOR ITS ENROLLEES UNDER CERTAIN TERMS AND CONDITIONS.

(B) "REASONABLE AND CUSTOMARY CHARGE" MEANS THE PREVAILING CHARGE WITHIN ANY GEOGRAPHIC AREA, NOT SMALLER THAN A STANDARD METROPOLITAN STATISTICAL AREA, FOR ANY GIVEN MEDICAL PROCEDURE.