**SENATE BILL NO. 1043**

April 14, 1998, Introduced by Senators BYRUM, BERRYMAN, DINGELL, A. SMITH, O'BRIEN, CHERRY and DE BEAUSSAERT and referred to the Committee on Health Policy and Senior Citizens.

A bill to regulate certain managed care plans; to create the office of the managed care ombudsman and to prescribe its powers and duties; to create a health care data committee and to prescribe its powers and duties; to prescribe the powers and duties of certain state agencies and persons; to provide for certain surveys and reports; and to prescribe penalties.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

ARTICLE 1

Sec. 101. This act shall be known and may be cited as the "health care accountability act".

Sec. 103. As used in this act:

(a) "Council" means the legislative council established under section 15 of article IV of the state constitution of 1963.

(b) "Commissioner" means the state commissioner of insurance.

(c) "Department" means the department of community health.

(d) "Director" means the director of the department of community health.

(e) "Enrollee" means an individual who is entitled to receive health services under a managed care plan.

(f) "Health professional" or "health profession" means that term as defined in section 16105 of the public health code, 1978 PA 368, MCL 333.16105.

(g) "Managed care plan" means a health plan offered by a health maintenance organization licensed under part 210 of the public health code, 1978 PA 368, MCL 333.21001 to 333.21098, or a policy, certificate, or contract offered by a health insurer or health care corporation under which covered individuals elect to obtain health care services from health care providers who have entered into prudent purchaser agreements.

(h) "Office" means the office of the managed care ombudsman created in article 2.

(i) "Ombudsman" means the managed care ombudsman created in article 2.

(j) "Utilization review" means a system for prospective and concurrent review of the medical necessity and appropriateness in the allocation of health care resources and services given or proposed to be given to an enrollee in a managed care plan. Utilization review does not include elective requests for clarification of coverage.

(k) "Utilization review accreditation commission" means the American accreditation healthcare commission/utilization review accreditation commission.

Sec. 104. (1) A managed care plan that has allegedly violated any part of this act shall be afforded an opportunity for a hearing before the commissioner of insurance pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. If the commissioner finds that a violation has occurred, the commissioner shall reduce the findings and decision to writing and shall issue and cause to be served upon the managed care plan charged with the violation a copy of the findings and an order requiring the plan to cease and desist from the violation. In addition, the commissioner may order any of the following:

(a) Payment of a civil fine of not more than $500.00 for each violation. An order of the commissioner under this subdivision shall not require the payment of civil fines exceeding $25,000.00. A fine collected under this subdivision shall be turned over to the state treasurer and credited to the general fund.

(b) The suspension, limitation, or revocation of the managed care plan's license or certificate of authority.

(2) After notice and opportunity for hearing, the commissioner may by order reopen and alter, modify, or set aside, in whole or in part, an order issued under this section if, in the commissioner's opinion, conditions of fact or law have changed to require that action or the public interest requires that action.

(3) The commissioner may apply to the Ingham county circuit court for an order of the court enjoining a violation of this act.

ARTICLE 2

Sec. 201. (1) The managed care ombudsman's office is created within the legislative council.

(2) The principal executive officer of the office is the managed care ombudsman who shall be appointed by and serve at the pleasure of the council.

(3) The council shall establish procedures for approving the office's budget, expending funds, and employing the ombudsman and personnel for the office.

Sec. 203. The ombudsman shall do all of the following:

(a) Advise the legislature on issues regarding managed care.

(b) Review and comment on managed care issues involving the department or the insurance bureau of the department of consumer and industry services.

(c) Research and investigate matters that affect the quality, delivery, costs, management, and operation of managed care as it affects consumers.

(d) Provide technical assistance and act as a resource to consumers regarding managed care including all of the following:

(*i*) Educating enrollees about their rights and responsibilities.

(*ii*) Assisting enrollees with filing grievances or appeals of managed care plan determinations.

(*iii*) Disseminating information and reports concerning managed care plans and issues.

(e) Establish a statewide toll-free telephone line to give state residents access to the ombudsman's office.

(f) Perform other functions as determined by the council.

Sec. 205. (1) Correspondence between the ombudsman and a consumer is confidential and exempt from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(2) The ombudsman shall maintain secrecy with respect to all matters and the identities of complainants or persons from whom information is acquired, except to the extent disclosure is necessary to enable the ombudsman to perform the duties of the office or to support recommendations resulting from an investigation.

Sec. 207. The ombudsman shall submit to the council and the legislature an annual report on the actions of the office, on issues and matters under section 203(a), (b), and (c), and on the need for any suggested legislative action.

ARTICLE 3

Sec. 301. (1) A managed care plan shall not condition employment with the managed care plan or cancel coverage on, refuse to provide coverage for, or refuse to issue or renew a plan because an employee, an applicant for employment, an enrollee, or an applicant for enrollment refuses to have a genetic test or because of the results of a genetic test.

(2) As used in this section:

(a) "Genetic characteristic" means an inherited gene or chromosome, or alteration of a gene or chromosome, that is scientifically or medically believed to predispose an individual to a disease, disorder, or syndrome, or to be associated with a statistically significant increased risk of development of a disease, disorder, or syndrome.

(b) "Genetic test" means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids such as DNA, RNA, and mitochondrial DNA, chromosomes, or proteins, in order to identify a genetic characteristic.

Sec. 303. A managed care plan shall establish a policy governing termination of providers. The policy shall include, but is not limited to, all of the following:

(a) Notice to the provider of the termination in the time and manner specified in the provider's contract.

(b) Methods by which the termination policy will be made known to providers and enrollees at the time of enrollment and on a periodic basis.

(c) Written notification to each enrollee at least 30 business days prior to the termination or withdrawal from the managed care plan's provider network of an enrollee's primary care provider and any other provider from which the enrollee is currently receiving a course of treatment. The 30-day prior notice to enrollees may be waived in cases of immediate termination of a provider where it was necessary for the protection of the health, safety, and welfare of enrollees.

(d) Assurance of continued coverage of services at the contract price by a terminated provider for up to 120 calendar days where it is medically necessary for the enrollee to continue treatment with the terminated provider. If an enrollee is pregnant, medical necessity shall be considered demonstrated and coverage shall continue to the postpartum evaluation of the enrollee, up to 6 weeks after delivery. This subdivision does not apply if a provider is terminated by a managed care plan based in whole or in part on issues concerning inadequate care or if quality control standards have not been met by the provider.

Sec. 305. A managed care plan shall not terminate a health professional's contract with the managed care plan because of the utilization of services caused by 1 or more high utilization enrollees.

Sec. 307. (1) A managed care plan that wishes to perform utilization review in house shall do so only under either of the following circumstances:

(a) If the utilization review standards to be used have been approved or accredited by the utilization review accreditation commission.

(b) The plan has demonstrated to the commissioner that it adheres to utilization review standards that are substantially similar to standards approved or accredited by the utilization review accreditation commission and the standards provide the same or greater protection to the rights of enrollees whose care is reviewed.

(2) A managed care plan shall only contract with a utilization review company for the performance of utilization review services if the utilization review company shows either of the following:

(a) The utilization review company has been approved or accredited by the utilization review accreditation commission.

(b) The utilization review company has demonstrated to the commissioner that it adheres to utilization review standards that are substantially similar to standards approved or accredited by the utilization review accreditation commission and the standards provide the same or greater protection to the rights of enrollees whose care is reviewed.

ARTICLE 4

Sec. 401. (1) The department shall develop a performance and outcome measurement system for monitoring the quality of care provided to managed care plan enrollees. The data collected through this system shall be used by the department to do all of the following:

(a) Assist managed care plans and their providers in quality improvement efforts.

(b) Provide information on the performance of managed care plans for regulatory oversight.

(c) Subject to subsection (4), inform the legislature and consumers through a user-friendly annual report about individual managed care plan performances.

(d) Promote the standardization of data reporting by managed care plans and providers.

(2) The performance and outcome measures shall include population-based and patient-centered indicators of quality of care, appropriateness, access, utilization, and satisfaction. To minimize costs to managed care plans, providers, and the department, performance measures will incorporate, when possible, data routinely collected or available to the department from other sources. The department shall take all necessary measures to reduce duplicative reporting of information to state agencies. Sources of data for these performance measures may include but are not limited to all of the following:

(a) Indicator data collected by managed care plans from chart reviews and administrative data bases.

(b) Member and patient satisfaction surveys.

(c) Provider surveys.

(d) Quarterly and annual reports submitted by managed care plans to the department.

(e) Computerized health care encounter data.

(f) Data collected by the department for administrative, epidemiological, and other purposes.

(3) The department shall make, when appropriate, statistically valid adjustments in its annual report to account for demographic variations among managed care plans.

(4) Each managed care plan shall have 30 days to comment on the compilation and interpretation of the data before its release to consumers.

Sec. 403. (1) Managed care plans shall submit such performance and outcome data as the department requests from time to time.

(2) A managed care plan shall disclose upon request how much of each premium dollar is spent on administrative costs.

Sec. 405. The department shall conduct audits at least once every 3 years of each managed care plan's performance and outcome data including desk and on-site audits.

Sec. 407. The department shall conduct or arrange for periodic enrollee satisfaction surveys. The managed care plan shall provide the department with the enrollee mailing list, upon request, to be used to select samples of the managed care plans membership for the surveys.

Sec. 409. The department shall ensure the confidentiality of patient-specific information.

Sec. 411. (1) The department shall establish a health care data committee to assist the department in developing a performance measurement and assessment system for monitoring the quality of care provided to managed care plan enrollees.

(2) The health care data committee shall be composed of no more than 12 and no fewer than 10 members who are appointed by and serve at the pleasure of the director and the commissioner. The members shall include providers, consumers, and at least 3 managed care plan representatives. In addition, the director and the commissioner shall serve as ex officio members without vote. The health care data committee shall be chaired by the director

or his or her designee. Additional experts may be invited to participate on an invitational ad hoc basis as needed.

(3) The health care data committee shall advise the director and the commissioner on the development of a uniform data reporting system to obtain reliable, standardized, and comparable information from all managed care plans. In the process of developing this system, the health care data committee shall address all of the following:

(a) The relevance, validity, and reliability of each measure selected to be an indicator of performance.

(b) Protection of confidentiality of patient-specific information.

(c) Cost and difficulty of data collection and existing data collection requirements.

(d) Measures to reduce duplicative reporting of information to state agencies.

(e) Public release of data in formats useful to purchasers and consumers.

ARTICLE 5

Sec. 501. This act takes effect January 1, 1999.