HOUSE BILL NO. 5491

February 22, 2024, Introduced by Rep. Schriver and referred to the Committee on Government Operations.

A bill to amend 1980 PA 350, entitled

"The nonprofit health care corporation reform act,"

by amending sections 401, 417, and 502 (MCL 550.1401, 550.1417, and 550.1502), section 401 as amended by 2003 PA 59, section 417 as amended by 1994 PA 235, and section 502 as amended by 2014 PA 261.

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 that it elects to furnish into classes or kinds.

(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) Rate, cancel benefits on, refuse to provide benefits for, or refuse to issue or continue a certificate solely because a subscriber or applicant is or has been a victim of domestic violence. A health care corporation ~~shall~~ **is** not ~~be held~~ civilly liable for any cause of action that may result from compliance with

this subdivision. This subdivision applies to all health care corporation certificates issued or renewed on or after June 1, 1998. As used in this subdivision, "domestic violence" means inflicting bodily injury, causing serious emotional injury or psychological trauma, or placing in fear of imminent physical harm by threat or force ~~a person~~ **an individual** who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

(e) Require a member or his or her dependent or an applicant for coverage or his or her dependent to do either of the following:

(*i*) Undergo genetic testing before issuing, renewing, or continuing a health care corporation certificate.

(*ii*) Disclose whether genetic testing has been conducted or the results of genetic testing or genetic information.

(4) 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 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.

(d) For groups of under 100 subscribers and except as otherwise provided in section 3709 of the insurance code of 1956, 1956 PA 218, MCL 500.3709, that the group that the individual is a member of has failed to enroll enough of its eligible members with

the health care corporation. A denial under this subdivision ~~shall~~ **must** be made only if the health care corporation determines that the cost for the portion of the group applying for coverage would be at least 50% more on a per subscriber basis than the per subscriber cost for the whole group. A denial under this subdivision ~~shall~~ **must** not be based on the health status of any individual in the group or his or her dependent. A denial under this subdivision ~~shall~~ **must** be based on sound actuarial principles and may be based on 1 or more of the following:

(*i*) That the contract holder for the group applying for coverage is also offering a self-funded health benefit plan.

(*ii*) That the group applying for coverage is composed entirely of the contract holder's retiree business segment.

(*iii*) That the average individual age of the members of the group applying for coverage is either 50% higher or 10 years higher than the average individual age for the whole group.

(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~~ **must** 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~~ **must** be payable pursuant to the coordination of benefits act, 1984 PA 64, MCL 550.251 to ~~550.255.~~**550.254.**

(6) A health care corporation ~~shall have~~ **has** 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.~~**Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations.**

(b) Meet the certification standards of the ~~medicare~~ **Medicare** program and the ~~medicaid~~ **Medicaid** program.

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

(c) ~~(d)~~ Follow generally accepted accounting principles and practices.

(d) ~~(e)~~ Have a community advisory board.

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

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

(9) Not later than the close of business on the seventh business day after denying coverage under subsection (4)(d), the health care corporation shall notify the commissioner of this denial and shall supply the commissioner with the information used in determining the denial. The commissioner shall determine whether he or she ~~will approve or disapprove~~ **approves** the health care corporation denial not later than the close of business on the seventh business day after receipt of the notice and shall promptly notify the health care corporation of his or her determination. The commissioner shall base his or her determination under this subsection on whether the health care corporation met the standards in subsection (4)(d). The health care corporation or the denied contract holder may appeal the commissioner's decision in circuit court. The commissioner shall report to the senate and house of representatives standing committees on insurance issues by May 15, 2005 and biennially thereafter all of the following:

(a) The number of denials made each calendar year by a health care corporation under subsection (4)(d).

(b) The number of denials under subdivision (a) that were approved by the commissioner under this subsection and a summary of the type of group approved.

(c) The number of denials under subdivision (a) that were disapproved by the commissioner under this subsection and a summary of the type of group disapproved.

(d) The number of decisions by the commissioner under this subsection that have been appealed and the results of the appeals.

(10) As used in this section:

(a) "Clinical purposes" includes all of the following:

(*i*) Predicted risk of diseases.

(*ii*) Identifying carriers for single-gene disorders.

(*iii*) Establishing prenatal and clinical diagnosis or prognosis.

(*iv*) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families.

(*v*) Tests for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.

(*vi*) Other tests if their intended purpose is diagnosis of a presymptomatic genetic condition.

(b) "Genetic information" means information about a gene, gene product, or inherited characteristic derived from a genetic test.

(c) "Genetic test" means the analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome ~~in order~~ to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including, but not limited to, a chemical analysis, of body fluids, unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.

Sec. 417. (1) A health care corporation shall offer to include benefits for hospice care in each certificate that provides benefits for inpatient hospital care.

(2) A health care corporation may ~~enter into contracts~~ **contract** with health care providers for the rendering of hospice

care. A contracting health care provider shall be a licensed hospice under article 17 of the public health code, ~~Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22260 of the Michigan Compiled Laws,~~ **1978 PA 368, MCL 333.20101 to 333.22121,** and shall meet the standards set by the corporation for contracting health care providers.

(3) If benefits for hospice care are provided, a description of the hospice benefit ~~shall~~ **must** be included in communications sent to the individual or group purchaser of coverage.

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services or with health practitioners practicing legally in any other jurisdiction for health care services that the professional health care providers or practitioners may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies all of the following to the health care corporation:

(a) That the provider ~~will~~ **shall** accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

(b) That the provider ~~will~~ **shall** accept payment from the corporation as payment in full for all cases involving the procedure specified, for the duration of the calendar year. As used in this subdivision, provider does not include ~~a person~~ **an individual** licensed as a dentist under part 166 of the public health code, 1978 PA 368, MCL 333.16601 to ~~333.16648.~~**333.16659.**

(c) That the provider ~~will~~ **shall** not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into under subsection (1) ~~shall~~ **must** provide that the private provider-patient relationship ~~shall~~ **must** be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which it has contracted before August 27, 1985 and that continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection does not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, or to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services that are overutilized, including those services rendered, ordered, or prescribed to an extent that is greater than reasonably necessary.

(4) A health care corporation may provide to a member, ~~upon~~ **on** request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an

individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or ~~a person~~ **an individual** on the board of directors of the corporation, who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation ~~, which~~ **that** can be publicly displayed ~~,~~ to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section does not impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section with professional health care providers licensed in this state are subject to sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities ~~,~~ **and** is licensed under part 208 of the public health code, 1978 PA 368, MCL 333.20801 to 333.20821. ~~, and complies with part 222 of the public health code, 1978 PA 368, MCL 333.22201 to 333.22260.~~

(9) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of

optometry service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(10) Notwithstanding any other provision of this act, a health care corporation is not required to reimburse for services otherwise covered under a certificate if the services were performed by a member of a health care profession ~~, which health care profession~~ **that** was not licensed or registered by this state on or before January 1, 1998 but that becomes a health care profession licensed or registered by this state after January 1, 1998. This subsection does not change the status of a health care profession that was licensed or registered by this state on or before January 1, 1998.

(11) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are within the scope of practice of chiropractic, a health care corporation is not required to provide benefits or reimburse for a practice of chiropractic service unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(12) Notwithstanding any other provision of this act, if a certificate provides for benefits for services that are provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist, a health care corporation is not required to provide benefits or reimburse for services provided by a physical therapist or physical therapist assistant unless that service was provided by a licensed physical therapist or physical therapist assistant under the supervision of

a licensed physical therapist pursuant to a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to ~~333.16648,~~ **333.16659**, 333.17001 to ~~333.17084,~~ **333.17097**, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No.____ or House Bill No. 5477 (request no. 01038'23) of the 102nd Legislature is enacted into law.