SUBSTITUTE FOR

SENATE BILL NO. 1150

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 3515, 3519, 3523, 3529, 3533, 3569, and 3571 (MCL 500.3515, 500.3519, 500.3523, 500.3529, 500.3533, 500.3569, and 500.3571), sections 3515 and 3519 as amended by 2002 PA 621, sections 3523 and 3529 as amended by 2002 PA 304, and sections 3533, 3569, and 3571 as added by 2000 PA 252.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 3515. (1) A health maintenance organization may provide additional health maintenance services or any other related health care service or treatment not required under this chapter.

(2) A health maintenance organization may have health maintenance contracts with deductibles. ~~A~~ **For specific health maintenance services, a** health maintenance organization may have

health maintenance contracts ~~with~~ **that require** copayments, ~~that are required for specific health maintenance services. Copayments for services required under section 3501(b)~~ **stated as dollar amounts for the cost of covered services, and coinsurance, stated as percentages for the cost of covered services. Coinsurance for basic health services and copayments for inpatient hospital services and facility-based outpatient surgical services,** excluding deductibles, ~~shall be nominal,~~ shall not exceed 50% of a health maintenance organization's reimbursement to an affiliated provider for providing the service to an enrollee ~~,~~ and shall not be based on the provider's standard charge for the service.

(3) An enrollee's aggregate out-of-pocket costs for coinsurance for basic health services and an enrollee's aggregate out-of-pocket costs for copayments for inpatient hospital services and facility-based outpatient surgical services shall not exceed $5,000.00 per year for an individual covered under a health maintenance contract and $10,000.00 per year for a family covered under a health maintenance contract. The maximum coinsurance and copayment out-of-pocket costs shall be adjusted annually to the greater of the following:

(a) By March 31 each year in accordance with the annual average percentage change in the consumer price index for all urban consumers in the United States city average for medical care for the 12-month period ending the preceding December 31, as reported by the United States department of labor, bureau of labor statistics, and as certified by the commissioner.

(b) The maximum annual out-of-pocket expenses for a high deductible health plan under section 223 of the internal revenue code, 26 USC 223, as certified by the commissioner.

(4) Upon petition by a health maintenance organization to the commissioner, the maximum coinsurance and co-payment out-of-pocket costs under subsection (3) shall be adjusted to an amount warranted by current market conditions. Within 90 days after the date of the petition, the commissioner shall make the adjustment or reject the adjustment as not being warranted by current market conditions. As used in this subsection:

(a) "Current market conditions" includes higher coinsurances and co-payments being used in the same or similar products marketed by other health insurers.

(b) "Health insurer" means a <<health maintenance organization, nonprofit health care corporation, or commercial insurer regulated by the insurance laws of this state and providing any form of health insurance or coverage.

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(5) A health maintenance organization may have health maintenance contracts under section 3533 with separate out-of-pocket costs for services performed by nonaffiliated providers that do not exceed 2 times the out-of-pocket costs under subsection (3) or (4) for services performed by affiliated providers. A health maintenance organization shall not have separate out-of-pocket costs under this subsection for emergency services or for services performed by nonaffiliated providers that are authorized by the health maintenance organization.

(6) A health maintenance organization shall not require contributions be made to a deductible for ~~preventative~~ **preventive** health care services. As used in this subsection, ~~"preventative~~ **"preventive** health care services" means services designated to maintain an individual in optimum health and to prevent unnecessary injury, illness, or disability.

(7) ~~(3)~~ A health maintenance organization may accept from governmental agencies and from private persons payments covering any part of the cost of health maintenance contracts.

Sec. 3519. (1) A health maintenance organization contract and the contract's rates, including any deductibles**,** ~~and~~ copayments, **and coinsurances,** between the organization and its subscribers shall be fair, sound, and reasonable in relation to the services provided, and the procedures for offering and terminating contracts shall not be unfairly discriminatory.

(2) A health maintenance organization contract and the contract's rates shall not discriminate on the basis of race, color, creed, national origin, residence within the approved service area of the health maintenance organization, lawful occupation, sex, handicap, or marital status, except that marital status may be used to classify individuals or risks for the purpose of insuring family units. The commissioner may approve a rate differential based on sex, age, residence, disability, marital status, or lawful occupation, if the differential is supported by sound actuarial principles, a reasonable classification system, and is related to the actual and credible loss statistics or reasonably anticipated experience for new

coverages.

(3) All health maintenance organization contracts shall include, at a minimum, basic health services.

Sec. 3523. (1) A health maintenance contract shall be filed with and approved by the commissioner.

(2) A health maintenance contract shall include any approved riders, amendments, and the enrollment application.

(3) In addition to the provisions of this act that apply to an expense-incurred hospital, medical, or surgical policy or certificate, a health maintenance contract shall include all of the following:

(a) Name and address of the organization.

(b) Definitions of terms subject to interpretation.

(c) The effective date and duration of coverage.

(d) The conditions of eligibility.

(e) A statement of responsibility for payments.

(f) A description of specific benefits and services available under the contract within the service area, with respective copayments**, coinsurances,** and deductibles.

(g) A description of emergency and out-of-area services.

(h) A specific description of any limitation, exclusion, and exception, including any preexisting condition limitation, grouped together with captions in boldfaced type.

(i) Covenants that address confidentiality, an enrollee's right to choose or change the primary care physician or other providers, availability and accessibility of services, and any rights of the enrollee to inspect and review his or her medical

records.

(j) Covenants of the subscriber shall address all of the following subjects:

(*i*) Timely payment.

(*ii*) Nonassignment of benefits.

(*iii*) Truth in application and statements.

(*iv*) Notification of change in address.

(*v*) Theft of membership identification.

(k) A statement of responsibilities and rights regarding the grievance procedure.

(*l*) A statement regarding subrogation and coordination of benefits provisions, including any responsibility of the enrollee to cooperate.

(m) A statement regarding conversion rights.

(n) Provisions for adding new family members or other acquired dependents, including conversion of individual contracts to family contracts and family contracts to individual contracts, and the time constraints imposed.

(o) Provisions for grace periods for late payment.

(p) A description of any specific terms under which the health maintenance organization or the subscriber can terminate the contract.

(q) A statement of the nonassignability of the contract.

Sec. 3529. (1) A health maintenance organization may contract with or employ health professionals on the basis of cost, quality, availability of services to the membership, conformity to the administrative procedures of the health

maintenance organization, and other factors relevant to delivery of economical, quality care, but shall not discriminate solely on the basis of the class of health professionals to which the health professional belongs.

(2) A health maintenance organization shall enter into contracts with providers through which health care services are usually provided to enrollees under the health maintenance organization plan.

(3) An affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments**, coinsurances,** and deductibles directly from enrollees.

(4) An affiliated provider contract shall contain provisions assuring all of the following:

(a) The provider meets applicable licensure or certification requirements.

(b) Appropriate access by the health maintenance organization to records or reports concerning services to its enrollees.

(c) The provider cooperates with the health maintenance organization's quality assurance activities.

(5) The commissioner may waive the contract requirement under subsection (2) if a health maintenance organization has demonstrated that it is unable to obtain a contract and accessibility to patient care would not be compromised. When 10% or more of a health maintenance organization's elective inpatient admissions, or projected admissions for a new health maintenance

organization, occur in hospitals with which the health maintenance organization does not have contracts or agreements that protect enrollees from liability for authorized admissions and services, the health maintenance organization may be required to maintain a hospital reserve fund equal to 3 months' projected claims from such hospitals.

(6) A health maintenance organization shall submit to the commissioner for approval standard contract formats proposed for use with its affiliated providers and any substantive changes to those contracts. The contract format or change is considered approved 30 days after filing unless approved or disapproved within the 30 days. As used in this subsection, "substantive changes to contract formats" means a change to a provider contract that alters the method of payment to a provider, alters the risk assumed by each party to the contract, or affects a provision required by law.

(7) A health maintenance organization or applicant shall provide evidence that it has employed, or has executed affiliation contracts with, a sufficient number of providers to enable it to deliver the health maintenance services it proposes to offer.

Sec. 3533. (1) A health maintenance organization may offer prudent purchaser contracts to groups or individuals and in conjunction with those contracts a health maintenance organization may pay or may reimburse enrollees, or may contract with another entity to pay or reimburse enrollees, for unauthorized services or for services by nonaffiliated providers

in accordance with the terms of the contract and subject to copayments, **coinsurances,** deductibles, or other financial penalties designed to encourage enrollees to obtain services from the organization's providers.

(2) Prudent purchaser contracts and the rates charged for them are subject to the same regulatory requirements as health maintenance contracts. The rates charged by an organization for coverage under contracts issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the organization for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(3) A health maintenance organization shall not issue prudent purchaser contracts unless it is in full compliance with the requirements for adequate working capital, statutory deposits, and reserves as provided in this chapter and it is not operating under any limitation to its authorization to do business in this state.

(4) A health maintenance organization shall maintain financial records for its prudent purchaser contracts and activities in a form separate or separable from the financial records of other operations and activities carried on by the organization.

Sec. 3569. (1) Except as provided in section 3515(2), **(3), (4), and (5),** a health maintenance organization shall assume full financial risk on a prospective basis for the provision of health

maintenance services. However, the organization may do any of the following:

(a) Require an affiliated provider to assume financial risk under the terms of its contract.

(b) Obtain insurance.

(c) Make other arrangements for the cost of providing to an enrollee health maintenance services the aggregate value of which is more than $5,000.00 in a year for that enrollee.

(2) If the health maintenance organization requires an affiliated provider to assume financial risk under the terms of its contract, the contract shall require both of the following:

(a) The health maintenance organization to pay the affiliated provider, including a subcontracted provider, directly or through a licensed third party administrator for health maintenance services provided to its enrollees.

(b) The health maintenance organization to keep all pooled funds and withhold amounts and account for them on its financial books and records and reconcile them at year end in accordance with the written agreement between the affiliated provider and the health maintenance organization.

(3) As used in this section, "requiring an affiliated provider to assume financial risk" means a transaction whereby a portion of the chance of loss, including expenses incurred, related to the delivery of health maintenance services is shared with an affiliated provider in return for a consideration. These transactions include, but are not limited to, full or partial capitation agreements, withholds, risk corridors, and indemnity

agreements.

Sec. 3571. A health maintenance organization is not precluded from meeting the requirements of, receiving ~~moneys~~ **money** from, and enrolling beneficiaries or recipients of ~~,~~ state and federal health programs. **A health maintenance organization that participates in a state or federal health program shall meet the solvency and financial requirements of this act but is not required to offer benefits or services that exceed the requirements of the state or federal health program. This section does not apply to state employee or federal employee health programs.**