SUBSTITUTE FOR

SENATE BILL NO. 88

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 3515, 3517, 3519, 3523, 3529, 3533, 3539, and 3571 (MCL 500.3515, 500.3517, 500.3519, 500.3523, 500.3529, 500.3533, 500.3539, and 500.3571), sections 3515 and 3519 as amended by 2002 PA 621, sections 3517, 3533, 3539, and 3571 as added by 2000 PA 252, and sections 3523 and 3529 as amended by 2002 PA 304.

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 health maintenance organization may have health maintenance contracts ~~with~~ **THAT INCLUDE** 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,** 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. **THIS SUBSECTION DOES NOT LIMIT THE COMMISSIONER'S AUTHORITY TO REGULATE AND ESTABLISH FAIR, SOUND, AND REASONABLE COPAYMENT AND COINSURANCE LIMITS INCLUDING OUT OF POCKET MAXIMUMS.**

(3) BY MAY 15, 2008, AND BY EACH MAY 15 AFTER 2008, THE COMMISSIONER SHALL MAKE A DETERMINATION AS TO WHETHER THE GREATER COPAYMENT AND COINSURANCE LEVELS ALLOWED BY THE AMENDATORY ACT THAT ADDED THIS SUBSECTION HAVE INCREASED THE NUMBER OF EMPLOYERS WHO HAVE CONTRACTED FOR HEALTH MAINTENANCE ORGANIZATION SERVICES AND WHETHER THESE LEVELS HAVE INCREASED THE NUMBER OF ENROLLEES RECEIVING HEALTH MAINTENANCE ORGANIZATION SERVICES. IN MAKING THIS DETERMINATION, THE COMMISSIONER SHALL HOLD A PUBLIC HEARING BY FEBRUARY 1, 2008, AND MAY HOLD A PUBLIC HEARING THEREAFTER, SHALL SEEK THE ADVICE AND INPUT FROM APPROPRIATE INDEPENDENT SOURCES, INCLUDING, BUT NOT LIMITED TO, ALL HEALTH MAINTENANCE ORGANIZATIONS OPERATING IN THIS STATE AND WITH ENROLLEES IN THIS STATE, AND SHALL ISSUE A REPORT DELINEATING SPECIFIC EXAMPLES OF COPAYMENT AND

COINSURANCE LEVELS IN FORCE AND SUGGESTIONS TO INCREASE THE NUMBER OF PERSONS ENROLLED IN HEALTH MAINTENANCE ORGANIZATIONS.

(4) IF THE RESULTS OF THE REPORT ISSUED UNDER SUBSECTION (3) ARE DISPUTED OR IF THE COMMISSIONER DETERMINES THAT THE CIRCUMSTANCES THAT THE REPORT WAS BASED ON HAVE CHANGED, THE COMMISSIONER SHALL ISSUE A SUPPLEMENTAL REPORT TO THE REPORT UNDER SUBSECTION (3) THAT INCLUDES COPIES OF THE WRITTEN OBJECTIONS DISPUTING THE COMMISSIONER'S REPORT DETERMINATIONS OR THAT SPECIFIES THE CHANGE OF CIRCUMSTANCES. THE SUPPLEMENTAL REPORT SHALL BE ISSUED NOT LATER THAN DECEMBER 15 IMMEDIATELY FOLLOWING THE RELEASE OF THE REPORT UNDER SUBSECTION (3) THAT THIS REPORT SUPPLEMENTS AND SHALL BE SUPPORTED BY SUBSTANTIAL EVIDENCE.

(5) ALL OF THE FOLLOWING SHALL BE CONSIDERED BY THE COMMISSIONER FOR PURPOSES OF SUBSECTIONS (3) AND (4):

(A) INFORMATION AND DATA GATHERED FROM HEALTH MAINTENANCE ORGANIZATIONS REGARDING THE EFFECTS OF GREATER COPAYMENT AND COINSURANCE LEVELS ALLOWED BY THE AMENDATORY ACT THAT ADDED THIS SUBSECTION.

(B) INFORMATION AND DATA PROVIDED BY EMPLOYERS WHO EMPLOY RESIDENTS OF THIS STATE.

(C) ANY OTHER INFORMATION AND DATA THE COMMISSIONER CONSIDERS RELEVANT.

(6) THE REPORTS AND CERTIFICATIONS REQUIRED UNDER SUBSECTIONS (3) AND (4) SHALL BE FORWARDED TO THE GOVERNOR, THE CLERK OF THE HOUSE OF REPRESENTATIVES, THE SECRETARY OF THE SENATE, AND ALL MEMBERS OF THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON INSURANCE AND HEALTH ISSUES.

(7) 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.

(8) ~~(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. 3517. (1) A health maintenance contract shall not provide for payment of cash or other material benefit to an enrollee, except as stated in this chapter.

(2) SUBSECTION (1) DOES NOT PROHIBIT A HEALTH MAINTENANCE ORGANIZATION FROM PROMOTING OPTIMUM HEALTH BY OFFERING TO ALL CURRENTLY ENROLLED SUBSCRIBERS OR TO ALL CURRENTLY COVERED ENROLLEES 1 OR MORE HEALTHY LIFESTYLE PROGRAMS. A "HEALTHY LIFESTYLE PROGRAM" MEANS A PROGRAM RECOGNIZED BY A HEALTH MAINTENANCE ORGANIZATION THAT ENHANCES HEALTH OR REDUCES RISK OF DISEASE, INCLUDING, BUT NOT LIMITED TO, PROMOTING NUTRITION AND PHYSICAL EXERCISE AND COMPLIANCE WITH DISEASE MANAGEMENT PROGRAMS AND PREVENTIVE SERVICE GUIDELINES THAT ARE SUPPORTED BY EVIDENCE-BASED MEDICAL PRACTICE. SUBSECTION (1) DOES NOT PROHIBIT A HEALTH MAINTENANCE ORGANIZATION FROM OFFERING A CURRENTLY ENROLLED SUBSCRIBER OR CURRENTLY COVERED ENROLLEE GOODS, VOUCHERS, OR EQUIPMENT THAT SUPPORTS ACHIEVING OPTIMAL HEALTH GOALS. AN OFFERING OF GOODS, VOUCHERS, OR EQUIPMENT UNDER THIS SUBSECTION IS NOT A VIOLATION OF SUBSECTION (1) AND SHALL NOT BE CONSIDERED VALUABLE

CONSIDERATION, A MATERIAL BENEFIT, A GIFT, A REBATE, OR AN INDUCEMENT UNDER THIS ACT.

(3) ~~(2)~~ For an emergency episode of illness or injury that requires immediate treatment before it can be secured through the health maintenance organization, or for an out-of-area service specifically authorized by the health maintenance organization, an enrollee may utilize a provider within or without this state not normally engaged by the health maintenance organization to render service to its enrollees. The organization shall pay reasonable expenses or fees to the provider or enrollee as appropriate in an individual case. These transactions are not considered acts of insurance and, except as provided in this chapter and section 3406k, are not otherwise subject to this act.

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. **A HEALTHY LIFESTYLE PROGRAM AS DEFINED IN SECTION 3517(2) IS NOT SUBJECT TO THE COMMISSIONER'S APPROVAL UNDER THIS SUBSECTION AND IS NOT REQUIRED TO BE SUPPORTED BY SOUND ACTUARIAL PRINCIPLES, A REASONABLE CLASSIFICATION SYSTEM, OR BE RELATED TO 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. 3539. (1) For an individual covered under a nongroup

contract or under a contract not covered under subsection (2), a health maintenance organization may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the health maintenance contract.

(2) A health maintenance organization shall not exclude or limit coverage for a preexisting condition for an individual covered under a group contract.

(3) Except as provided in subsection (5), a health maintenance organization that has issued a nongroup contract shall renew or continue in force the contract at the option of the individual.

(4) Except as provided in subsection (5), a health maintenance organization that has issued a group contract shall renew or continue in force the contract at the option of the sponsor of the plan.

(5) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health maintenance organization no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(6) A HEALTH MAINTENANCE ORGANIZATION IS NOT REQUIRED TO CONTINUE A HEALTHY LIFESTYLE PROGRAM OR TO CONTINUE ANY INCENTIVE ASSOCIATED WITH A HEALTHY LIFESTYLE PROGRAM, INCLUDING, BUT NOT LIMITED TO, GOODS, VOUCHERS, OR EQUIPMENT.

(7) ~~(6)~~ As used in this section, "group" means a group of 2

or more subscribers.

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, UNLESS THE HEALTH MAINTENANCE ORGANIZATION IS IN RECEIVERSHIP OR UNDER SUPERVISION, 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.**