SENATE BILL No. 1237

August 15, 2012, Introduced by Senators MARLEAU and JANSEN and referred to the Committee on Health Policy.

A bill to amend 1978 PA 368, entitled

"Public health code,"

(MCL 333.1101 to 333.25211) by adding sections 22216, 22217, and 22218.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 22216. (1) AS USED IN THIS SECTION AND SECTIONS 22217 AND 22218:

(A) "COMMISSIONER" MEANS THE COMMISSIONER OF THE OFFICE OF FINANCIAL AND INSURANCE REGULATION.

(B) "CPT CODE" MEANS THE APPLICABLE CURRENT PROCEDURAL TERMINOLOGY CODE AS ADOPTED BY THE AMERICAN MEDICAL ASSOCIATION OR, IF A CPT CODE IS NOT AVAILABLE, THE APPLICABLE CODE UNDER AN APPROPRIATE UNIFORM CODING SCHEME APPROVED BY THE COMMISSION.

(C) "DATABASE" MEANS THE MICHIGAN MEDICAL CARE DATABASE ESTABLISHED UNDER THIS SECTION.

SENATE BILL No. 1237

(D) "HEALTH BENEFIT PLAN" MEANS A POLICY, CONTRACT, CERTIFICATE, OR AGREEMENT OFFERED OR ISSUED BY A HEALTH CARRIER TO PROVIDE, DELIVER, ARRANGE FOR, PAY FOR, OR REIMBURSE ANY OF THE COSTS OF HEALTH CARE SERVICES. HEALTH BENEFIT PLAN DOES NOT INCLUDE ANY OF THE FOLLOWING:

(*i*) COVERAGE ONLY FOR ACCIDENT OR DISABILITY INCOME INSURANCE OR ANY COMBINATION OF THOSE COVERAGES.

(*ii*) COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY INSURANCE.

(*iii*) LIABILITY INSURANCE, INCLUDING GENERAL LIABILITY INSURANCE AND AUTOMOBILE LIABILITY INSURANCE.

(*iv*) WORKER'S COMPENSATION OR SIMILAR INSURANCE.

(*v*) AUTOMOBILE MEDICAL PAYMENT INSURANCE.

(*vi*) CREDIT-ONLY INSURANCE.

(*vii*) COVERAGE FOR ON-SITE MEDICAL CLINICS.

(*viii*) OTHER SIMILAR INSURANCE COVERAGE, SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, PUBLIC LAW 104-191, UNDER WHICH BENEFITS FOR HEALTH CARE SERVICES ARE SECONDARY OR INCIDENTAL TO OTHER INSURANCE BENEFITS.

(*ix*) A PLAN THAT PROVIDES THE FOLLOWING BENEFITS IF THOSE BENEFITS ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE OR ARE OTHERWISE NOT AN INTEGRAL PART OF THE PLAN:

(A) LIMITED SCOPE DENTAL OR VISION BENEFITS.

(B) BENEFITS FOR LONG-TERM CARE, NURSING HOME CARE, HOME HEALTH CARE, COMMUNITY-BASED CARE, OR ANY COMBINATION OF THOSE BENEFITS.

(C) OTHER SIMILAR, LIMITED BENEFITS SPECIFIED IN FEDERAL REGULATIONS ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, PUBLIC LAW 104-191.

(*x*) A PLAN THAT PROVIDES THE FOLLOWING BENEFITS IF THE BENEFITS ARE PROVIDED UNDER A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE, THERE IS NO COORDINATION BETWEEN THE PROVISION OF THE BENEFITS AND ANY EXCLUSION OF BENEFITS UNDER ANY GROUP HEALTH BENEFIT PLAN MAINTAINED BY THE SAME PLAN SPONSOR, AND THE BENEFITS ARE PAID WITH RESPECT TO AN EVENT WITHOUT REGARD TO WHETHER BENEFITS ARE PROVIDED WITH RESPECT TO SUCH AN EVENT UNDER ANY GROUP HEALTH BENEFIT PLAN MAINTAINED BY THE SAME PLAN SPONSOR:

(A) COVERAGE ONLY FOR A SPECIFIED DISEASE OR ILLNESS.

(B) HOSPITAL INDEMNITY OR OTHER FIXED INDEMNITY INSURANCE.

(*xi*) ANY OF THE FOLLOWING IF OFFERED AS A SEPARATE POLICY, CERTIFICATE, OR CONTRACT OF INSURANCE:

(A) A MEDICARE SUPPLEMENTAL POLICY AS DEFINED IN SECTION 1882(G)(1) OF THE SOCIAL SECURITY ACT, 42 USC 1395SS.

(B) COVERAGE SUPPLEMENTAL TO THE COVERAGE PROVIDED BY THE TRICARE PROGRAM UNDER 10 USC 1071 TO 1110B.

(C) SIMILAR COVERAGE SUPPLEMENTAL TO COVERAGE PROVIDED UNDER A GROUP HEALTH PLAN.

(E) "HEALTH CARE SERVICE" MEANS ANY HEALTH OR MEDICAL CARE PROCEDURE OR SERVICE RENDERED BY A HEALTH PROVIDER THAT MEETS EITHER OF THE FOLLOWING REQUIREMENTS:

(*i*) PROVIDES TESTING, DIAGNOSIS, OR TREATMENT OF HUMAN DISEASE OR DYSFUNCTION.

(*ii*) DISPENSES DRUGS, MEDICAL DEVICES, MEDICAL APPLIANCES, OR

MEDICAL GOODS FOR THE TREATMENT OF HUMAN DISEASE OR DYSFUNCTION.

(F) "HEALTH CARRIER" OR "CARRIER" MEANS ANY OF THE FOLLOWING ENTITIES THAT ARE SUBJECT TO THE INSURANCE LAWS AND REGULATIONS OF THIS STATE OR OTHERWISE SUBJECT TO THE JURISDICTION OF THE COMMISSIONER:

(*i*) A HEALTH INSURER OPERATING PURSUANT TO THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302.

(*ii*) A HEALTH MAINTENANCE ORGANIZATION OPERATING PURSUANT TO THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302.

(*iii*) A HEALTH CARE CORPORATION OPERATING PURSUANT TO THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704.

(*iv*) A NONPROFIT DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO 550.373.

(*v*) ANY OTHER ENTITY PROVIDING A PLAN OF HEALTH INSURANCE, HEALTH BENEFITS, OR HEALTH SERVICES.

(G) NOTWITHSTANDING SECTION 22205, "HEALTH FACILITY" MEANS A HEALTH FACILITY OR AGENCY AS THAT TERM IS DEFINED IN SECTION 20106.

(H) "HEALTH PROFESSIONAL" MEANS AN INDIVIDUAL WHO IS LICENSED OR OTHERWISE AUTHORIZED TO ENGAGE IN A HEALTH PROFESSION UNDER ARTICLE 15.

(I) "HEALTH PROVIDER" MEANS A HEALTH FACILITY OR HEALTH PROFESSIONAL THAT RENDERS A HEALTH CARE SERVICE TO A PATIENT.

(2) THE COMMISSION SHALL ESTABLISH AND ADMINISTER A MICHIGAN MEDICAL CARE DATABASE TO COMPILE STATEWIDE DATA FROM CARRIERS ON THE COST OF HEALTH CARE SERVICES RENDERED BY HEALTH PROVIDERS IN THIS STATE.

(3) A CARRIER SHALL NOT SUBMIT ANY PERSONAL IDENTIFYING INFORMATION, INCLUDING SOCIAL SECURITY NUMBER, WITH REGARD TO ANY PATIENT, INSURED, OR ENROLLEE WHEN SUBMITTING DATA REQUIRED UNDER THIS SECTION AND SECTION 22217.

(4) IN ADDITION TO ANY OTHER DATA REQUIRED BY RULE PROMULGATED UNDER THIS PART, THE COMMISSION SHALL ENSURE THAT THE DATABASE IS ABLE TO COLLECT ALL OF THE FOLLOWING FROM CARRIERS:

(A) FOR EACH TYPE OF PATIENT ENCOUNTER WITH A HEALTH PROVIDER DESIGNATED BY THE COMMISSION, ALL OF THE FOLLOWING:

(*i*) THE DEMOGRAPHIC CHARACTERISTICS OF THE PATIENT.

(*ii*) THE PRINCIPAL DIAGNOSIS.

(*iii*) THE HEALTH CARE SERVICE RENDERED TO THE PATIENT.

(*iv*) THE DATE AND LOCATION WHERE THE HEALTH CARE SERVICE WAS RENDERED.

(*v*) THE CHARGE FOR THE HEALTH CARE SERVICE AND THE PORTION OF THE CHARGE PAID BY THE CARRIER AND THE PORTION PAYABLE BY THE PATIENT.

(*vi*) WHETHER THE BILL FOR THE HEALTH CARE SERVICE WAS SUBMITTED ON AN ASSIGNED OR NONASSIGNED BASIS.

(*vii*) IF APPLICABLE, THE HEALTH PROFESSIONAL'S UNIVERSAL IDENTIFICATION NUMBER.

(*viii*) IF THE HEALTH PROFESSIONAL RENDERING THE HEALTH CARE SERVICE IS A REGISTERED PROFESSIONAL NURSE WHO HAS A SPECIALTY CERTIFICATION AS A NURSE ANESTHETIST OR NURSE MIDWIFE, THE IDENTIFICATION MODIFIER FOR THAT NURSE ANESTHETIST OR NURSE MIDWIFE.

(B) APPROPRIATE DATA FROM A CARRIER RELATING TO PRESCRIPTION

DRUGS FOR EACH TYPE OF PATIENT ENCOUNTER WITH A PHARMACIST DESIGNATED BY THE COMMISSION.

(C) APPROPRIATE DATA RELATING TO HEALTH CARE COSTS, UTILIZATION, OR RESOURCES FROM CARRIERS AND GOVERNMENTAL AGENCIES.

(5) THE COMMISSION SHALL PROMULGATE RULES UNDER THE ADMINISTRATIVE PROCEDURES ACT OF 1969 THAT GOVERN THE ACCESS AND RETRIEVAL OF ALL MEDICAL CLAIMS DATA AND OTHER DATA COLLECTED AND STORED IN THE DATABASE AND ANY CLAIMS CLEARINGHOUSE APPROVED BY THE COMMISSION. THE COMMISSION, IN CONSULTATION WITH THE COMMISSIONER, CARRIERS, HEALTH FACILITIES, AND HEALTH PROFESSIONALS, MAY PROMULGATE RULES FOR THE ELECTRONIC SUBMISSION OF DATA AND SUBMISSION AND TRANSFER OF UNIFORM CLAIM FORMS IN USE IN THIS STATE.

(6) THE COMMISSION AND ANY RULES PROMULGATED BY THE COMMISSION SHALL ENSURE THAT CONFIDENTIAL OR PRIVILEGED PATIENT DATA ARE KEPT CONFIDENTIAL. THE COMMISSION SHALL PROVIDE THAT ANY RECORDS OR DATA THAT ARE SUBJECT TO A HEALTH PROFESSIONAL-PATIENT PRIVILEGE CREATED OR RECOGNIZED BY LAW ARE FILED IN A MANNER THAT DOES NOT COLLECT PERSONAL IDENTIFYING INFORMATION AND DOES NOT DISCLOSE THE IDENTITY OF THE INDIVIDUAL PROTECTED.

(7) TO THE EXTENT PRACTICABLE, WHEN COLLECTING THE DATA REQUIRED UNDER THIS SECTION AND SECTION 22217, THE COMMISSION SHALL UTILIZE ANY STANDARDIZED CLAIM FORM OR ELECTRONIC TRANSFER SYSTEM BEING USED BY CARRIERS, HEALTH FACILITIES, AND HEALTH PROFESSIONALS.

SEC. 22217. (1) IN DEVELOPING THE DATABASE, THE COMMISSION SHALL CONSULT WITH REPRESENTATIVES OF CARRIERS, HEALTH FACILITIES,

AND HEALTH PROFESSIONALS TO ENSURE THAT THE DATABASE IS COMPATIBLE WITH DATA COLLECTED AND USED BY THOSE INDIVIDUALS AND ENTITIES. THE COMMISSION SHALL ESTABLISH A PROCESS THAT REQUIRES CARRIERS TO SUBMIT DATA TO THE DATABASE ON A QUARTERLY BASIS.

(2) THE COMMISSION MAY CONTRACT WITH 1 OR MORE QUALIFIED, NONGOVERNMENTAL, INDEPENDENT THIRD PARTIES FOR SERVICES NECESSARY TO CARRY OUT THE DATA COLLECTION, PROCESSING, AND STORAGE ACTIVITIES REQUIRED UNDER THIS SECTION AND SECTIONS 22216 AND 22218. UNLESS PERMISSION IS SPECIFICALLY GRANTED BY THE COMMISSION, A THIRD PARTY HIRED BY THE COMMISSION UNDER THIS SUBSECTION SHALL NOT RELEASE, PUBLISH, OR OTHERWISE USE ANY DATA TO WHICH THE THIRD PARTY HAS ACCESS UNDER ITS CONTRACT AND SHALL OTHERWISE COMPLY WITH THE REQUIREMENTS OF THIS SECTION AND SECTIONS 22216 AND 22218.

(3) A CARRIER THAT VIOLATES THIS SECTION IS SUBJECT TO AN ADMINISTRATIVE FINE OF $10,000.00 FOR EACH FAILURE TO FILE DATA AS REQUIRED BY THE COMMISSION. THE COMMISSION SHALL REPORT TO THE COMMISSIONER A CARRIER THAT HAS FAILED TO FILE DATA AS REQUIRED BY THE COMMISSION FOR A PERIOD OF 12 MONTHS OR MORE.

SEC. 22218. (1) BEGINNING WITH THE FIRST FEBRUARY 1 AFTER THE EFFECTIVE DATE OF THIS SECTION, THE COMMISSION SHALL PUBLISH AN ANNUAL REPORT FOR THE IMMEDIATELY PRECEDING CALENDAR YEAR THAT INCLUDES ALL OF THE FOLLOWING:

(A) FOR THE HEALTH CARE SERVICES SELECTED BY THE COMMISSION, A DESCRIPTION OF ALL OF THE FOLLOWING:

(*i*) THE VARIATION IN FEES CHARGED BY HEALTH FACILITIES AND HEALTH PROFESSIONALS.

(*ii*) THE GEOGRAPHIC VARIATION IN THE UTILIZATION OF THOSE

HEALTH CARE SERVICES.

(B) THE TOTAL REIMBURSEMENT FOR ALL HEALTH CARE SERVICES.

(C) THE TOTAL REIMBURSEMENT FOR EACH HEALTH CARE SPECIALTY.

(D) THE TOTAL REIMBURSEMENT FOR EACH CPT CODE.

(E) THE ANNUAL RATE OF CHANGE IN REIMBURSEMENT FOR HEALTH CARE SERVICES BY HEALTH CARE SPECIALTIES AND BY CPT CODE.

(F) ANY OTHER INFORMATION THE COMMISSION CONSIDERS APPROPRIATE, INCLUDING INFORMATION ON CAPITATED HEALTH CARE SERVICES.

(2) THE COMMISSION SHALL MAKE THE DATA COLLECTED BY THE DATABASE AND ITS REPORTS AVAILABLE ON ITS INTERNET WEBSITE.