[No. 235]

(SB 662)

AN ACT to amend 1956 PA 218, entitled "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for regulation over worker's compensation self-insurers; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to repeal acts and parts of acts; and to provide penalties for the violation of this act," by amending section 2212a (MCL 500.2212a), as amended by 1998 PA 424.

The People of the State of Michigan enact:

500.2212a Policy or certificate issued under chapter 34 or 36; description of terms, conditions, and information; written request; "board certified" defined.

Sec. 2212a. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate issued under chapter 34 or 36 shall provide a written form in plain English to insureds upon enrollment that

describes the terms and conditions of the insurer's policies and certificates. The form shall provide a clear, complete, and accurate description of all of the following, as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of the insured's financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment if a provider's participation terminates during the course of an insured person's treatment by that provider.

(g) The telephone number to call to receive information concerning grievance procedures.

(h) How the covered benefits apply in the evaluation and treatment of pain.

(i) A summary listing of the information available pursuant to subsection (2).

(2) An insurer shall provide upon request to insureds covered under a policy or certificate issued under section 3405 or 3631 a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the policy or certificate's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.

(b) The professional credentials of participating health professionals, including, but not limited to, participating health professionals who are board certified in the specialty of pain medicine and the evaluation and treatment of pain and have reported that certification to the insurer, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the health professional presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the Michigan department of consumer and industry services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(e) Indication of the financial relationships between the insurer and any closed provider panel including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the insurer additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) shall be provided in writing. An insurer may require that a request under subsection (2) be submitted in writing.

(4) As used in this section, "board certified" means certified to practice in a particular medical or other health professional specialty by the American board of medical specialties or another appropriate national health professional organization.

Construction of § 500.2212a.

Enacting section 1. The 2001 amendatory act that added section 2212a(4) to the insurance code of 1956, 1956 PA 218, MCL 500.2212a, shall not be construed as creating a new mandated benefit for any coverages issued under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

This act is ordered to take immediate effect.
Approved January 3, 2002.
Filed with Secretary of State January 3, 2002.