HOUSE BILL No. 5572

February 12, 1998, Introduced by Reps. Schroer, Wallace, Anthony, Parks, LaForge, Baade, Bogardus, Crissman, Scott, Brater, Profit, Murphy, Hale and Gire and referred to the Committee on Insurance.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending section 2213 (MCL 500.2213), as added by 1996 PA 517.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2213. (1) By October 1, 1997, an insurer shall establish an internal formal grievance procedure for approval by the insurance bureau for persons covered under a policy or certificate issued under chapter 34 or 36 that includes all of the following:

(a) Provides for a designated person responsible for administering the grievance system.

(b) Provides a designated person or telephone number for receiving complaints.

(c) Ensures full investigation of a complaint.

(d) Provides for timely notification to the insured as to the progress of an investigation.

(e) Provides an insured the right to appear before the board of directors or designated committee or the right to a managerial-level conference to present a grievance.

(f) Provides for notification to the insured of the results of the insurer's investigation and for advisement of the insured's right to review the grievance by the commissioner.

(g) Provides summary data on the number and types of complaints filed.

(h) Provides for periodic management and governing body review of the data to assure that appropriate actions have been taken.

(i) Provides for copies of all complaints and responses to be available at the principal office of the insurer for inspection by the insurance bureau for 2 years following the year the complaint was filed.

(j) That when an adverse determination is made, a written statement containing the reasons for the adverse determination will be provided to the insured person.

(k) That a written notification of the grievance procedures will be provided to the insured person when the insured person contests an adverse determination.

(*l*) That a final determination will be made in writing by the insurer not later than 90 calendar days after a formal grievance is submitted in writing by the insured person. The

timing for the 90-calendar-day period may be tolled, however, for any period of time the insured person is permitted to take under the grievance procedure.

(m) That an initial determination will be made by the insurer not later than 72 hours after receipt of an expedited grievance. Within 3 business days after the initial determination by the insurer, the insured or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the insured may request further review by the insurer or for a determination of the matter by the commissioner or his or her designee. If further review is requested, a final determination by the insurer shall be made not later than 30 days after receipt of the request for further review. Within 10 days after receipt of a final determination, the insured or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the insured may request a determination of the matter by the commissioner or his or her designee. If the initial or final determination by the insurer is made orally, the insurer shall provide a written confirmation of the determination to the insured not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (*l*) would acutely jeopardize the life of the insured.

(n) That the insured person has the right to a determination of the matter by the commissioner or his or her designee.

(2) The commissioner shall establish a procedure for a determination of a grievance under this section ~~which~~ THAT shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the insured and the insurer. This procedure is not a contested case under the administrative procedures act of 1969, ~~Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws~~ 1969 PA 306, MCL 24.201 TO 24.328, and is not appealable under ~~Act No. 306 of the Public Acts of 1969~~ THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969 PA 306, MCL 24.201 TO 24.328.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) THE INSURER SHALL PROVIDE ALL INSUREDS WHO MEET THE CRITERIA IN SECTION 7(1) OF THE EXPERIMENTAL TREATMENT DISPUTE RESOLUTION ACT WITH NOTICE OF THE INSURED'S OPTION TO HAVE THE INSURER'S DENIAL OF A REQUEST FOR EXPERIMENTAL OR INVESTIGATIONAL THERAPY REVIEWED. THE INSURER SHALL NOTIFY ELIGIBLE INSUREDS IN WRITING OF THE OPPORTUNITY TO REQUEST AN EXTERNAL, INDEPENDENT REVIEW PURSUANT TO THE EXPERIMENTAL TREATMENT DISPUTE RESOLUTION ACT WITHIN 5 BUSINESS DAYS OF THE DECISION TO DENY COVERAGE. THE NOTICE SHALL INCLUDE A DESCRIPTION OF THE EXTERNAL, INDEPENDENT REVIEW PROCESS, THE ADDRESS OF THE EXPERIMENTAL TREATMENT DISPUTE RESOLUTION COMMISSION, THE INFORMATION THE INSURED MUST PROVIDE TO THE EXPERIMENTAL TREATMENT DISPUTE RESOLUTION COMMISSION UNDER THE EXPERIMENTAL TREATMENT DISPUTE RESOLUTION ACT, AND NOTICE

THAT THE INSURER MUST BE PROVIDED WITH NOTICE BY THE INSURED IF THE INSURED WISHES TO REQUEST AN EXTERNAL, INDEPENDENT REVIEW. WITHIN 5 BUSINESS DAYS OF THE INSURER'S RECEIPT OF A REQUEST BY AN INSURED FOR AN EXTERNAL, INDEPENDENT REVIEW, THE INSURER SHALL PROVIDE TO THE EXPERIMENTAL TREATMENT DISPUTE RESOLUTION COMMISSION THE DOCUMENTS REQUIRED UNDER SECTION 7(2) OF THE EXPERIMENTAL TREATMENT DISPUTE RESOLUTION ACT.

(5) ~~(4)~~ As used in this section:

(a) "Adverse determination" means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

(b) "Grievance" means a complaint on behalf of an insured person submitted by an insured person or a person, including, but not limited to, a physician, authorized in writing to act on behalf of the insured person regarding:

(*i*) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(*ii*) Benefits or claims payment, handling, or reimbursement for health care services.

(*iii*) Matters pertaining to the contractual relationship between an insured and the insurer.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. ___ or House Bill No. ___ (request no. 03595'97) of the 89th Legislature is enacted into law.