HOUSE BILL No. 5511

March 15, 2000, Introduced by Reps. Shulman, Hart, DeWeese, Gilbert and Kowall and referred to the Committee on Health Policy.

A bill to provide review of certain health care treatment decisions; to provide for a health care coverage complaint system; to provide for review of health care coverage treatment decisions by independent review organizations; to prescribe the powers and duties of certain health care coverage issuers; to prescribe the powers and duties of certain persons; to prescribe the powers and duties of certain state officials; to provide for the reporting of certain information; to provide fees; and to provide penalties for violations of this act.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. This act shall be known and may be cited as the "health care treatment decision review act".

Sec. 3. As used in this act:

(a) "Adverse determination" means a determination by a health care coverage issuer that the health care services

HOUSE BILL No. 5511

furnished or proposed to be furnished to an enrollee are not appropriate or medically necessary.

(b) "Alternative system of health care delivery and financing" means a person operating a system of health care delivery and financing under section 21042 of the public health code, 1978 PA 368, MCL 333.21042.

(c) "Commissioner" means the commissioner of insurance.

(d) "Dental care corporation" means a dental care corporation incorporated under 1963 PA 125, MCL 550.351 to 550.373.

(e) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(f) "Health care corporation" means a health care corporation operating under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(g) "Health care coverage issuer" means an insurer, a dental care corporation, health care corporation, health maintenance organization, managed care entity, alternative system of health care delivery and financing, or a physician service organization, physician hospital organization, group medical practice, or other similar entity.

(h) "Health care plan" means a plan or other arrangement whereby a health care coverage issuer undertakes to provide, arrange for, pay for, or reimburse any part of the cost of health care services.

(i) "Health care provider" means a health facility or a person licensed, certified, or registered under parts 61 to 65 or

161 to 183 of the public health code, 1978 PA 368, MCL 333.6101 to 333.6523 and 333.16101 to 333.18311.

(j) "Health facility" means:

(*i*) A facility or agency licensed or authorized under parts 201 to 217 of the public health code, 1978 PA 368, MCL 333.20101 to 333.21799e, or a licensed part thereof.

(*ii*) A mental hospital, psychiatric hospital, psychiatric unit, or mental retardation facility operated by the department of community health or certified or licensed under the mental health code, 1974 PA 258, MCL 330.1001 to 330.2106.

(*iii*) A facility providing outpatient physical therapy services, including speech pathology services.

(*iv*) A kidney disease treatment center, including a free-standing hemodialysis unit.

(*v*) An ambulatory health care facility.

(*vi*) A tertiary health care service facility.

(*vii*) A substance abuse treatment program licensed under parts 61 to 65 of the public health code, 1978 PA 368, MCL 333.6101 to 333.6523.

(*viii*) An outpatient psychiatric clinic.

(*ix*) A home health agency.

(k) "Health maintenance organization" means a health maintenance organization licensed under part 210 of the public health code, 1978 PA 368, MCL 333.21001 to 333.21098.

(*l*) "Independent review organization" means an organization designated by the commissioner under section 9.

(m) "Insurer" means a health insurer authorized to do business in this state under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(n) "Managed care entity" means an entity that delivers, administers, or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization, or costs and prices of those services to a defined enrollee population.

(o) "Physician" means a person licensed as a doctor of allopathic medicine or as a doctor of osteopathic medicine and surgery under part 170 or 175 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17084 and 333.17501 to 333.17556.

Sec. 5. (1) Except as provided in subsection (2), every health care coverage issuer shall establish for approval by the commissioner a complaint system to provide reasonable and prompt procedures for the resolution of oral and written complaints initiated by enrollees concerning health care services.

(2) Subsection (1) does not apply but subsection (4) does apply to a health care issuer that has an internal formal grievance procedure established under section 21035 of the public health code, 1978 PA 368, MCL 333.21035, section 2213 of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or section 404 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404.

(3) The commissioner shall promulgate pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to

24.328, rules and standards for complaint systems for health care coverage issuers.

(4) Every health care coverage issuer's complaint system shall include all of the following:

(a) Written notification to the commissioner of each enrollee who appeals, whether through the internal formal grievance procedure or through the independent review organization review procedure, an adverse determination made by the health care issuer.

(b) A process by which an enrollee or a person acting on behalf of the enrollee, including the enrollee's health care provider, shall be permitted by the health care coverage issuer to seek review of an adverse determination by an independent review organization.

(c) Written notification to an enrollee of the enrollee's right to review of an adverse determination by an independent review organization and the procedures to obtain that review.

(d) Written notification to an enrollee of the enrollee's right to expedited review by an independent review organization, and the procedures to obtain that review, if for a denial of a continued hospital stay or if the enrollee's physician, whether orally or in writing, substantiates that the normal time frame for review by an independent review organization would acutely jeopardize the health or life of the enrollee.

(5) The written notice to the enrollee required by subsection (4) shall include all of the following:

(a) A clear and concise written statement of the clinical basis for the adverse determination.

(b) A list of all documents reviewed or relied upon by the health care coverage issuer in making the adverse determination.

(c) The name and a description of the qualifications and clinical experience of each person making the denial.

(6) A health care coverage issuer shall provide to the appropriate independent review organization not later than the third business day after the date that the health care coverage issuer receives a request for review, or immediately for an expedited review, a copy of all of the following:

(a) Any medical records of the enrollee that are relevant to the review.

(b) Any documents reviewed or relied upon by the health care coverage issuer in making the adverse determination.

(c) The written notification to the enrollee required by subsection (4).

(d) Any documentation and written information submitted to the health care coverage issuer in support of the enrollee’s request for review.

(e) A list of each health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal.

(7) A health care coverage issuer shall pay for the independent review and shall comply with the independent review organization’s determination with respect to the medical

necessity or appropriateness of health care items and services for an enrollee.

(8) Confidential information in the custody of a health care coverage issuer may be provided to an independent review organization, subject to rules and standards adopted by the commissioner.

Sec. 7. (1) An enrollee shall not resubmit for review to the same or a different independent review organization the same issue that has already been determined by an independent review organization.

(2) A person shall not maintain a cause of action against a health care coverage issuer based on an adverse determination, unless the enrollee has first exhausted review by an independent review organization.

(3) If the enrollee or the enrollee’s representative seeks to exhaust the appeal and review, as required by subsection (2), before the statute of limitations applicable to a claim against a health care coverage issuer has expired, the limitations period is tolled until the later of the thirtieth day after the date the enrollee or the enrollee’s representative has exhausted the applicable process for appeal and review.

(4) This section does not prohibit an enrollee from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places the enrollee’s health or life in serious jeopardy.

Sec. 9. (1) The commissioner shall do all of the following:

(a) Promulgate pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, rules and standards for the certification, selection, and operation of independent review organizations and for the suspension and revocation of a certification.

(b) Designate annually each organization that meets the standards as an independent review organization and who has been certified by the commissioner under subdivision (a).

(c) Provide ongoing oversight of independent review organizations to ensure continued compliance with this act and the standards and rules adopted under this act.

(d) Report to the senate and house of representatives standing committees on health and insurance issues by April 1, 2002, and annually thereafter, on whether or not grievance and independent review organization procedures should apply to third party administrators and on the number of enrollees appealing an adverse determination made by a health care issuer in the immediately preceding calendar year disaggregated as follows:

(*i*) The number of enrollees per health care issuer appealing an adverse determination through the internal formal grievance procedure.

(*ii*) The number of enrollees per health care issuer appealing an adverse determination through the independent review organization procedure.

(2) The standards required by subsection (1) shall ensure all of the following:

(a) The timely response of an independent review organization to a request for an independent review of an adverse determination.

(b) The confidentiality of medical records transmitted to an independent review organization for use in independent reviews.

(c) The qualifications and independence of each health care provider making review determinations for an independent review organization, including standards that ensure that each health care provider making review determinations spend over 20% of their time in active clinical practice and have the same provider license as the health care provider providing the medical services that are under review.

(d) The fairness of the procedures used by an independent review organization in making the determinations.

(e) Timely notice to enrollees and health care coverage issuers of the results of the independent review, including the clinical basis for the determination.

(f) That independent review organizations disclose to enrollees and health care coverage issuers the names of each health care provider making review determinations, their specialty areas, the states in which they practice, and the justifications for their decision.

(3) The standards required under subsection (1) shall include standards that require each independent review organization to make its determination as follows:

(a) Except as provided in subdivision (b), not later than the earlier of the fifteenth day after the date the independent review organization receives the information necessary to make the determination.

(b) If immediate review is required, not later than the earlier of the fifth day after the date the independent review organization receives the information necessary to make the determination.

(4) To be certified as an independent review organization, an organization shall submit to the commissioner an application in the form required by the commissioner. The application shall include all of the following:

(a) For an applicant that is publicly held, the name of each stockholder or owner of more than 5% of any stock or options.

(b) The name of any holder of bonds or notes of the applicant that exceed $100,000.00.

(c) The name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control.

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under subdivision (c) and a description of any relationship the named individual has with a health care coverage issuer.

(e) The percentage of the applicant’s revenues that are anticipated to be derived from independent reviews.

(f) A description of the areas of expertise of the health care professionals making review determinations for the applicant.

(g) The procedures to be used by the independent review organization in making review determinations with respect to independent reviews.

(5) The independent review organization shall annually submit the information required by subsection (4). If at any time there is a material change in the information included in the application under subsection (4), the independent review organization shall submit updated information to the commissioner.

(6) An independent review organization may not be a subsidiary of, or in any way owned or controlled by, a health care coverage issuer or a trade association of health care coverage issuers.

(7) An independent review organization conducting a review is not liable for damages arising from the determination made by the organization. This subsection does not apply to an act or omission of the independent review organization that is made in bad faith or that involves gross negligence.

Sec. 11. If, after opportunity for a hearing held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the commissioner determines that a health care coverage issuer has violated this act, the commissioner shall reduce his or her findings and decision to writing and shall issue and cause to be served upon the health care coverage

issuer a copy of the findings and an order requiring the health care coverage issuer to cease and desist from violating this act and ordering payment of a monetary penalty of $5,000.00 for each violation. The commissioner may bring a civil action to enforce any order issued under this act. This section does not prohibit the commissioner from taking enforcement action authorized by any other law, in addition to any action taken under this section.

Enacting section 1. This act takes effect on January 1, 2001 and applies to all adverse determinations made on and after January 1, 2001.