Act No. 251
Public Acts of 2000
Approved by the Governor
June 29, 2000
Filed with the Secretary of State
June 29, 2000
EFFECTIVE DATE: October 1, 2000

STATE OF MICHIGAN
90TH LEGISLATURE
REGULAR SESSION OF 2000

Introduced by Reps. LaSata, Woronchak, Jelinek, Allen, Howell, Shackleton, Voorhees, Geiger, DeVuyst, Birkholz, Pappageorge, Patterson, Cameron Brown, Kuipers, Richardville, Bishop, Faunce, Kukuk, Scranton, Bisbee, Law, Raczkowski, Sanborn and Cassis

ENROLLED HOUSE BILL No. 5576

AN ACT to provide review of certain health care coverage adverse determinations made by health carriers; to prescribe eligibility, powers, and duties of certain independent review organizations; to prescribe the powers and duties of certain health carriers; 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 "patient's right to independent review act".

Sec. 3. As used in this act:

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

(b) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(c) "Authorized representative" means any of the following:

(*i*) A person to whom a covered person has given express written consent to represent the covered person in an external review.

(*ii*) A person authorized by law to provide substituted consent for a covered person.

(*iii*) If the covered person is unable to provide consent, a family member of the covered person or the covered person's treating health care professional.

(d) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

(e) "Certification" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

(f) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.

(g) "Commissioner" means the commissioner of the office of financial and insurance services.

(h) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(i) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(j) "Covered person" means a policyholder, subscriber, member, enrollee, or other individual participating in a health benefit plan.

(k) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(*l*) "Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(m) "Expedited internal grievance" means an expedited grievance under section 2213(1)(*l*) of the insurance code of 1956, 1956 PA 218, MCL 500.2213, or section 404(4) of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1404.

(n) "Facility" or "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 psychiatric hospital, psychiatric unit, partial hospitalization psychiatric program, or center for persons with disabilities 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 freestanding 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.

(o) "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 covered health care services.

(p) "Health care professional" means 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 MCL 333.16101 to 333.18311.

(q) "Health care provider" or "provider" means a health care professional or a health facility.

(r) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(s) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit health care corporation, or any other entity providing a plan of health insurance, health benefits, or health services. Health carrier does not include a state department or agency.

(t) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to 1 or more of the following:

(*i*) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family.

(*ii*) The provision of health care services to an individual.

(*iii*) Payment for the provision of health care services to an individual.

(u) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations.

(v) "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

(w) "Protected health information" means health information that identifies an individual who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(x) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(y) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

(z) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

(aa) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health plans.

Sec. 5. (1) Except as otherwise provided in subsection (2), this act applies to all health carriers that provide or perform utilization review.

(2) This act does not apply to a policy or certificate that provides coverage only for specified accident or accident-only coverage, credit, disability income, hospital indemnity, long-term care insurance, or any other limited supplemental benefit other than specified disease, dental, vision care, or care provided pursuant to a system of health care delivery and financing operating under section 3573 of the insurance code of 1956, 1956 PA 218, MCL 500.3573, medicare supplement policy of insurance, coverage under a plan through medicare, or the federal employees health benefits program, any coverage issued under chapter 55 of title 10 of the United States Code, 10 U.S.C. 1071 to 1109, and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, worker's compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Sec. 7. (1) A health carrier shall provide written notice to a covered person in plain English of the internal grievance and external review processes at the time the health carrier sends written notice of an adverse determination.

(2) Except as provided in subsection (3)(a), a request for an external review under section 11 or 13 shall not be made until the covered person has exhausted the health carrier's internal grievance process provided for by law.

(3) The written notice of the right to request an external review for an adverse determination issued before the service is provided to a covered person shall be in plain English and shall include all of the following:

(a) A statement informing the covered person of all of the following:

(*i*) If the covered person has a medical condition where the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, as substantiated by a physician either orally or in writing, the covered person or the covered person's authorized representative may file a request for an expedited external review under section 13 at the same time the covered person or the covered person's authorized representative files a request for an expedited internal grievance subject to section 13(3).

(*ii*) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within the required time and without the covered person or the covered person's authorized representative requesting or agreeing to a delay, the covered person or the covered person's authorized representative may file a request for external review under section 9 and shall be considered to have exhausted the health carrier's internal grievance process for purposes of subsection (2).

(b) A copy of the description of both the standard and expedited external review procedures the health carrier is required to provide under section 25, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

(c) As part of any forms provided under subdivision (b), include an authorization form, or other document approved by the commissioner, by which the covered person, for purposes of conducting an external review under this act, authorizes the health carrier and health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

(4) The written notice of the right to request an external review for an adverse determination issued after the service was provided to the covered person shall be in plain English, shall include the standard external review procedures information required in subsection (3), and shall be provided to the covered person in the manner prescribed by the commissioner.

Sec. 9. Except for a request for an expedited external review under section 13, all requests for external review shall be made in writing to the commissioner.

Sec. 11. (1) Not later than 60 days after the date of receipt of a notice of an adverse determination or final adverse determination under section 7, a covered person or the covered person's authorized representative may file a request for an external review with the commissioner. Upon receipt of a request for an external review, the commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination that is the subject of the request.

(2) Not later than 5 business days after the date of receipt of a request for an external review, the commissioner shall complete a preliminary review of the request to determine all of the following:

(a) Whether the individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided.

(b) Whether the health care service that is the subject of the adverse determination or final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan.

(c) Whether the covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process.

(d) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review, including the health information release form.

(3) Upon completion of the preliminary review under subsection (2), the commissioner immediately shall provide a written notice in plain English to the covered person and, if applicable, the covered person's authorized representative as to whether the request is complete and whether it has been accepted for external review.

(4) If a request is accepted for external review, the commissioner shall do both of the following:

(a) Include in the written notice under subsection (3) a statement that the covered person or the covered person's authorized representative may submit to the commissioner in writing within 7 days following the date of receipt of the notice additional information and supporting documentation that the assigned independent review organization shall consider when conducting the external review.

(b) Immediately notify the health carrier in writing of the acceptance of the request for external review.

(5) If a request is not accepted for external review because the request is not complete, the commissioner shall inform the covered person and, if applicable, the covered person's authorized representative what information or materials are needed to make the request complete. If a request is not accepted for external review, the commissioner shall provide written notice in plain English to the covered person, if applicable, the covered person's authorized representative, and the health carrier of the reasons for its nonacceptance.

(6) At the time a request is accepted for external review, the commissioner shall assign an independent review organization that has been approved under this act to conduct the external review and to provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or the final adverse determination.

(7) In reaching a recommendation, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(8) Not later than 7 business days after the date of receipt of the notice under subsection (4)(b), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or the final adverse determination. Except as provided in subsection (9), failure by the health carrier or its designee utilization review organization to provide the documents and information within 7 business days shall not delay the conduct of the external review.

(9) Upon receipt of a notice from the assigned independent review organization that the health carrier or its designee utilization review organization has failed to provide the documents and information within 7 business days, the commissioner may terminate the external review and make a decision to reverse the adverse determination or final adverse determination and shall immediately notify the assigned independent review organization, the covered person, if applicable, the covered person's authorized representative, and the health carrier of his or her decision.

(10) The assigned independent review organization shall review all of the information and documents received under subsection (8) and any other information submitted in writing by the covered person or the covered person's authorized representative under subsection (4)(a) that has been forwarded to the independent review organization by the commissioner. Upon receipt of any information submitted by the covered person or the covered person's authorized representative under subsection (4)(a), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

(11) The health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review. Reconsideration by the health carrier of its adverse determination or final adverse determination does not delay or terminate the external review. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination. Immediately upon making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier.

(12) In addition to the documents and information provided under subsection (8), the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a recommendation:

(a) The covered person's pertinent medical records.

(b) The attending health care professional's recommendation.

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, the covered person, the covered person's authorized representative, or the covered person's treating provider.

(d) The terms of coverage under the covered person's health benefit plan with the health carrier.

(e) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

(13) The assigned independent review organization shall provide its recommendation to the commissioner not later than 14 days after acceptance by the commissioner of the request for an external review. The independent review organization shall include in its recommendation all of the following:

(a) A general description of the reason for the request for external review.

(b) The date the independent review organization received the assignment from the commissioner to conduct the external review.

(c) The date the external review was conducted.

(d) The date of its recommendation.

(e) The principal reason or reasons for its recommendation.

(f) The rationale for its recommendation.

(g) References to the evidence or documentation, including the practice guidelines, considered in reaching its recommendation.

(14) Upon receipt of the assigned independent review organization's recommendation under subsection (13), the commissioner immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

(15) The commissioner shall provide written notice in plain English to the covered person, if applicable, the covered person's authorized representative, and the health carrier of the decision to uphold or reverse the adverse determination or the final adverse determination not later than 7 business days after the date of receipt of the selected independent review organization's recommendation. The commissioner shall include in this notice all of the following:

(a) The principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner the commissioner considers appropriate, the information provided by the selected independent review organization under subsection (13).

(b) If appropriate, the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation.

(16) Upon receipt of a notice of a decision under subsection (15) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Sec. 13. (1) Except as provided in subsection (11), a covered person or the covered person's authorized representative may make a request for an expedited external review with the commissioner within 10 days after the covered person receives an adverse determination if both of the following are met:

(a) The adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the covered person or

would jeopardize the covered person's ability to regain maximum function as substantiated by a physician either orally or in writing.

(b) The covered person or the covered person's authorized representative has filed a request for an expedited internal grievance.

(2) At the time the commissioner receives a request for an expedited external review, the commissioner immediately shall notify and provide a copy of the request to the health carrier that made the adverse determination or final adverse determination. If the commissioner determines the request meets the reviewability requirements under section 11(2), the commissioner shall assign an independent review organization that has been approved under this act to conduct the expedited external review and to provide a written recommendation to the commissioner on whether to uphold or reverse the adverse determination or final adverse determination.

(3) If a covered person has not completed the health carrier's expedited internal grievance process, the independent review organization shall determine immediately after receipt of the assignment to conduct the expedited external review whether the covered person will be required to complete the expedited internal grievance prior to conducting the expedited external review. If the independent review organization determines that the covered person must first complete the expedited internal grievance process, the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review until the covered person completes the expedited internal grievance.

(4) In reaching a recommendation, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

(5) Not later than 12 hours after the health carrier receives the notice under subsection (2), the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(6) In addition to the documents and information provided or transmitted under subsection (5), the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a recommendation:

(a) The covered person's pertinent medical records.

(b) The attending health care professional's recommendation.

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider.

(d) The terms of coverage under the covered person's health benefit plan with the health carrier.

(e) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations.

(7) The assigned independent review organization shall provide its recommendation to the commissioner as expeditiously as the covered person's medical condition or circumstances require, but in no event more than 36 hours after the date the commissioner received the request for an expedited external review.

(8) Upon receipt of the assigned independent review organization's recommendation, the commissioner immediately shall review the recommendation to ensure that it is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier.

(9) As expeditiously as the covered person's medical condition or circumstances require, but in no event more than 24 hours after receiving the recommendation of the assigned independent review organization, the commissioner shall complete the review of the independent review organization's recommendation and notify the covered person, if applicable, the covered person's authorized representative, and the health carrier of the decision to uphold or reverse the adverse determination or final adverse determination. If this notice was not in writing, within 2 days after the date of providing that notice, the commissioner shall provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, and the health carrier and include the information required in section 11(15).

(10) Upon receipt of a notice of a decision under subsection (9) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

(11) An expedited external review shall not be provided for retrospective adverse determinations or retrospective final adverse determinations.

Sec. 15. (1) An external review decision and an expedited external review decision are the final administrative remedies available under this act.

(2) Subsection (1) does not preclude a health carrier from seeking other remedies available under applicable state law.

(3) Subsection (1) does not preclude a covered person from seeking other remedies available under applicable federal or state law.

(4) A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision under this act.

Sec. 17. (1) The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this act to ensure that an independent review organization satisfies the minimum standards established under section 19.

(2) The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(3) Any independent review organization wishing to be approved to conduct external reviews under this act shall submit the application form developed under subsection (2) and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under section 19. The commissioner may charge an application fee that independent review organizations shall submit to the commissioner with an application for approval and reapproval.

(4) An approval under this section is effective for 2 years, unless the commissioner determines before expiration of the approval that the independent review organization is not satisfying the minimum standards established under section 19. If the commissioner determines that an independent review organization no longer satisfies the minimum standards established under section 19, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this act that is maintained by the commissioner under subsection (5).

(5) The commissioner shall maintain and periodically update a list of approved independent review organizations.

Sec. 19. (1) To be approved under section 17 to conduct external reviews, an independent review organization shall do both of the following:

(a) Have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process under sections 11 and 13 that include, at a minimum, a quality assurance mechanism in place that does all of the following:

(*i*) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner.

(*ii*) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases.

(*iii*) Ensures the confidentiality of medical and treatment records and clinical review criteria.

(*iv*) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this act.

(b) Agree to maintain and provide to the commissioner the information required in section 23.

(2) A clinical peer reviewer assigned by an independent review organization to conduct external reviews shall be a physician or other appropriate health care professional who meets all of the following minimum qualifications:

(a) Is an expert in the treatment of the covered person's medical condition that is the subject of the external review.

(b) Is knowledgeable about the recommended health care service or treatment because he or she devoted in the immediately preceding year a majority of his or her time in an active clinical practice within the medical specialty most relevant to the subject of the review.

(c) Holds a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(d) Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

(3) An independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

(4) An independent review organization selected to conduct the external review and any clinical peer reviewer assigned by the independent organization to conduct the external review shall not have a material professional, familial, or financial conflict of interest with any of the following:

(a) The health carrier that is the subject of the external review.

(b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative.

(c) Any officer, director, or management employee of the health carrier that is the subject of the external review.

(d) The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review.

(e) The facility at which the recommended health care service or treatment would be provided.

(f) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(5) In determining whether an independent review organization or a clinical peer reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subsection (4), the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (4), but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer reviewer from conducting the external review.

Sec. 21. An independent review organization or clinical peer reviewer working on behalf of an independent review organization is not liable in damages to any person for any opinions rendered during or upon completion of an external review conducted under this act, unless the opinion was rendered in bad faith or involved gross negligence.

Sec. 23. (1) An independent review organization assigned to conduct an external review under section 11 or 13 shall maintain for 3 years written records in the aggregate and by health carrier on all requests for external review for which it conducted an external review during a calendar year. Each independent review organization required to maintain written records on all requests for external review for which it was assigned to conduct an external review shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(2) The report to the commissioner under subsection (1) shall include in the aggregate and for each health carrier all of the following:

(a) The total number of requests for external review.

(b) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination.

(c) The average length of time for resolution.

(d) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner.

(e) The number of external reviews under section 11(11) that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative.

(f) Any other information the commissioner may request or require.

(3) Each health carrier shall maintain for 3 years written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review that are filed with the health carrier or that the health carrier receives notice of from the commissioner under this act. Each health carrier required to maintain written records on all requests for external review shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(4) The report to the commissioner under subsection (3) shall include in the aggregate and by type of health benefit plan all of the following:

(a) The total number of requests for external review.

(b) From the number of requests for external review that are filed directly with the health carrier, the number of requests accepted for a full external review.

(c) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination.

(d) The average length of time for resolution.

(e) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner.

(f) The number of external reviews under section 11(11) that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative.

(g) Any other information the commissioner may request or require.

Sec. 25. (1) Each health carrier shall include a description of the internal grievance and external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(2) The description under subsection (1) shall be in plain English and shall include all of the following:

(a) A statement informing the covered person of his or her right to file a request for an internal grievance and external review of an adverse determination.

(b) The commissioner's toll-free telephone number and address.

(c) A statement informing the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Sec. 27. The commissioner may promulgate rules pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, necessary to carry out the provisions of this act.

Sec. 29. (1) If the commissioner finds that a violation of this act has occurred, the commissioner shall reduce the findings and decision to writing and shall issue and cause to be served upon the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from the violation. In addition, the commissioner may order any of the following:

(a) Payment of a civil fine of not more than $1,000.00 for each violation. However, if the person knew or reasonably should have known that he or she was in violation of this act, the commissioner may order the payment of a civil fine of not more than $5,000.00 for each violation.

(b) The suspension, limitation, or revocation of the person's license or certificate of authority.

(2) If the commissioner finds that a health carrier has deliberately refused to pay for a covered benefit, the commissioner may order any of the following:

(a) For a first offense, payment of a civil fine of not more than $25,000.00 and recovery of the cost of the investigation.

(b) For a second offense, payment of a civil fine of not more than $50,000.00 and recovery of the cost of the investigation.

(c) For a third or subsequent offense or if the commissioner determines that the health carrier has deliberately engaged in a pattern of refusing to pay for a covered benefit, both of the following:

(*i*) The greater of the following:

(A) Payment of a civil fine of not more than $280,000.00.

(B) Payment of a civil fine which shall be the amount of the health carrier's total liability for the covered benefits denied.

(*ii*) Recovery of the cost of the investigation.

(3) A fine collected under this section shall be placed in the cancer clinical trials fund created in subsection (7).

(4) A person who violates any provision of this act shall be afforded an opportunity for a hearing before the commissioner pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. After notice and opportunity for hearing, the commissioner may by order reopen and alter, modify, or set aside, in whole or in part, an order issued under this section if, in the commissioner's opinion, conditions of fact or law have changed to require that action or the public interest requires that action.

(5) If a person knowingly violates a cease and desist order under this section and has been given notice and an opportunity for a hearing held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, the commissioner may order a civil fine of $10,000.00 for each violation, or a suspension, limitation, or revocation of a person's license, or both.

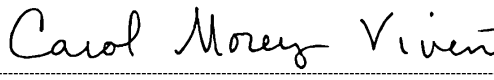
(6) The commissioner may apply to the Ingham county circuit court for an order of the court enjoining a violation of this act.

(7) The cancer clinical trials fund is created as a separate fund in the state treasury. The money in the fund shall be used as provided in this subsection. The state treasurer shall credit to the cancer clinical trials fund all fines collected under this section. The state treasurer may invest money in the fund in any manner authorized by law for the investment of state money, and earnings shall be credited to the fund. Money may be appropriated from the fund to hospitals, outpatient oncology centers, and other facilities located in this state involved in national institutes of health phase III or IV cancer clinical trials that apply for fund money to partially defray costs of patient participation in cancer clinical trials not covered by pharmaceutical manufacturers or health carriers. Money may be appropriated from the fund in amounts that shall not exceed $5,000.00 per facility per year. Money in the cancer clinical trials fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

Enacting section 1. This act takes effect October 1, 2000.

This act is ordered to take immediate effect.

Clerk of the House of Representatives.



Secretary of the Senate.

Approved _____

_____

Governor.