IRA: REVISE

House Bill 6494 (Substitute H-1)
Sponsor: Rep. Charles LaSata

House Bill 6495 as introduced
Sponsor: Rep. Gary A. Newell

Committee: Insurance and Financial Services

Complete to 12-4-02

A SUMMARY OF HOUSE BILLS 6494 AND 6495 AS REPORTED BY THE INSURANCE AND FINANCIAL SERVICES COMMITTEE

House Bill 6494 would amend the Patient's Right to Independent Review Act (PRIRA) to revise procedures and time frames regarding independent reviews and House Bill 6495 would amend the Insurance Code to delete a reference to a report that House Bill 6494 would eliminate. Specifically, the bills would do the following:

House Bill 6494 would make several changes to the Patient's Right to Independent Review Act (MCL 550.1911 et al.). The act enables persons with health insurance to request a review by an independent review organization (IRO) to resolve disputes over covered benefits. The IROs specifically review issues of medical necessity and clinical review criteria and the commissioner of the Office of Financial and Insurance Services (OFIS) conducts the external review if the request involves only a question of the contractual provisions of a person's health benefit plan, such as covered benefits or accuracy of coding.

Currently, the IRO must provide its recommendation to the commissioner not later than 14 days after the commissioner assigned the external review to that IRO. The bill would instead require the recommendation to be provided to the commissioner not later than 10 business days after the assignment was made or five business days after receipt of complete information pertaining to the person's request for review or documentation pertaining to the health carrier's adverse determination. In addition, under the act, if the commissioner keeps a request and conducts the external review, he or she must provide a written notice of his or her decision not later than 14 business days after the decision to keep the request; the bill would change the time frame to 10 business days.

"Business day" would mean any day on which the OFIS were open. Saturdays, Sundays, legal holidays, and any other day on which the OFIS were closed would be excluded. For the purpose of computing time, the day of the act or event after which the designated period of time began to run would not be included. The last day of the period would be included, unless it was one of the days that OFIS were closed, in which case the period would run until the end of the next day that was not a day that OFIS were closed.

Currently, a health carrier may reconsider its adverse determination that is the subject of the external review. The external review may, after the reconsideration, be terminated only if the health carrier decides to reverse the adverse determination. Instead, the bill would allow a health carrier to reverse the adverse determination in whole or in part. Moreover, if the health carrier made a partial reversal of its adverse determination and the covered person accepted the health carrier's decision, the person could withdraw his or her request for an external review.

If the commissioner determined that additional information or medical records not in the possession of the health carrier or covered person were needed to complete either a review by the commissioner or an IRO, or that additional review was needed by the IRO, the bill would allow the commissioner to issue an order to produce the additional information or records or to issue an order for additional IRO recommendations. The order would have to contain specific time frames in which the information would have to be provided. The commissioner could also issue an order necessary to administer a review. Time requirements under Section 11(16) would have to be tolled until the commissioner received the additional information or medical records, additional IRO recommendations, or confirmation of compliance with his or her order. The commissioner could proceed under provisions of the act that allow the review to be conducted even if the health carrier does not provide the requested information and records within the specified time frames.

Additionally, the act requires the commissioner, at the time he or she receives a request for an expedited external review, to immediately notify and provide a copy of the request to the health carrier that made the adverse determination. Also, if the commissioner determines that the request meets the requirement criteria specified in the act, he or she must assign an IRO to conduct the expedited external review. Instead, the bill would require the commissioner to do the above listed tasks not later than two hours after receiving the request for the expedited external review.

The act also allows a person aggrieved by an external review or an expedited external review decision to seek judicial review no later than 60 days after the decision in the Ingham County Circuit Court or the circuit court in the county where the person resides. The bill would add that the person would have to serve the commissioner with a copy of the petition for review. The bill would allow the commissioner to become a party to any judicial review of an external review by filing an appearance in the case. The health carrier in any judicial review not involving the commissioner would have to serve upon the commissioner a copy of the circuit court final order in the review.

Further, the act currently requires each health carrier to maintain certain written records for three years on all requests for external review and to submit an annual report with information about the external review requests to the commissioner. The bill would delete the requirement to submit an annual report and would instead require a health carrier to produce the records upon the commissioner's request.

House Bill 6495. The Insurance Code requires the commissioner of OFIS to prepare an annual consumer guide to health maintenance organizations (HMOs). The guide is available to the public upon request and through the Internet. In addition to information pertaining to

accreditation status and measurements of the quality of care provided by each HMO, the guide also must contain a summary of the report required to be provided to the commissioner under provisions of the Patient's Right to Independent Review Act (PRIRA), as discussed above. House Bill 6494 would eliminate the requirement for HMOs and other insurers to file this report. Therefore, House Bill 6495 would amend the Insurance Code (MCL 500.3580) to delete the requirement that the HMO guide contain a summary of the external review reports. Instead, the bill would require a summary for each HMO of the information required to be maintained by insurers pertaining to the requests received for external reviews. The information would have to include, but not be limited to, the following:

- The total number of requests for external review;

- the number of requests for external review that were resolved upholding the adverse determination or final adverse determination and the number that were resolved reversing the adverse determination or final determination;

- the average length of time for resolution;

- a summary of the types of coverages or cases for which an external review had been sought; and,

- the number of external reviews that were terminated as the result of a reconsideration by the HMO of its adverse determination or final adverse determination after the receipt of additional information from the covered person or his or her authorized representative.

The bill is tie-barred to House Bill 6494.

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