SENATE BILL No. 950

February 1, 2000, Introduced by Senators KOIVISTO, A. SMITH, DINGELL, EMERSON, DE BEAUSSAERT, BYRUM and MURPHY and referred to the Committee on Health Policy.

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~~ 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.

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(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~~ ALONG WITH a written notification IN PLAIN ENGLISH of the grievance procedures ~~will be provided to the insured person when the insured person contests an adverse determination~~ INCLUDING THE RIGHT TO A REVIEW BY THE COMMISSIONER.

(K) ~~(l)~~ That a final determination will be made in writing by the insurer not later than ~~90~~ 30 calendar days after a

formal grievance is submitted in writing by the insured person. The timing for the ~~90-calendar-day~~ 30-CALENDAR-DAY period may be tolled, however, for any period of time the insured person is permitted to take under the grievance procedure.

(*l*) ~~(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*)~~ (K) would acutely jeopardize the life of the insured.

(M) ~~(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 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) AN INSURED MAY AUTHORIZE IN WRITING ANY PERSON, INCLUDING, BUT NOT LIMITED TO, A PHYSICIAN, TO ACT ON HIS OR HER BEHALF AT ANY STAGE IN A GRIEVANCE PROCEEDING UNDER THIS SECTION.

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

(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~~ CONCERNING ANY OF THE FOLLOWING:

(*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.