SENATE BILL No. 1308

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September 25, 2012, Introduced by Senator MARLEAU 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 amended by 2002 PA 707.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 2213. (1) Except as otherwise provided in subsection (4),
2 each insurer and health maintenance organization shall establish an
3 internal formal grievance procedure for approval by the
4 commissioner for persons covered under a policy, certificate, or
5 contract issued under chapter 34, 35, or 36 that ~~includes~~ **PROVIDES**
6 **FOR** all of the following:

7 (a) ~~Provides for a~~ **A** designated person responsible for
8 administering the grievance system.

9 (b) ~~Provides a~~ **A** designated person or telephone number for
10 receiving ~~complaints~~ **GRIEVANCES**.

11 (c) ~~Ensures~~ **A METHOD THAT ENSURES** full investigation of a

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~~complaint~~ **GRIEVANCE**.

(d) ~~Provides for timely~~ **TIMELY** notification in plain English to the insured or enrollee as to the progress of an investigation **OF A GRIEVANCE**.

(e) ~~Provides~~ **THE RIGHT OF** an insured or enrollee ~~the right~~ to appear before ~~the board of directors or~~ **A** designated **PERSON OR** committee ~~or the right to a managerial level conference~~ to present a grievance.

(f) ~~Provides for notification~~ **NOTIFICATION** in plain English to the insured or enrollee of the results of the insurer's or health maintenance organization's investigation **OF THE GRIEVANCE** and ~~for advisement~~ of the ~~insured's or enrollee's~~ right to ~~review~~ **HAVE** the grievance **REVIEWED** by the commissioner or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) ~~Provides~~ **A METHOD FOR PROVIDING** summary data on the number and types of complaints and grievances filed **UNDER THIS SECTION**. ~~Beginning April 15, 2001, this~~ **THE INSURER OR HEALTH MAINTENANCE ORGANIZATION SHALL ANNUALLY FILE THE** summary data for the prior calendar year ~~shall be filed annually~~ with the commissioner on forms provided by the commissioner.

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

(i) ~~Provides for~~ **THAT** copies of all complaints and responses ~~to be~~ **ARE** available at the principal office of the insurer or health maintenance organization for inspection by the commissioner

1 for 2 years following the year the ~~complaint~~ **GRIEVANCE** was filed.
2 (j) That when an adverse determination is made, a written
3 statement in plain English containing the reasons for the adverse
4 determination is provided to the insured or enrollee along with
5 written notifications as required under the patient's right to
6 independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.
7 (k) That a final determination will be made in writing by the
8 insurer or health maintenance organization not later than 35
9 calendar days after a formal grievance is submitted in writing by
10 the insured or enrollee. The timing for the 35-calendar-day period
11 may be tolled, however, for any period of time the insured or
12 enrollee is permitted to take under the grievance procedure and for
13 a period of time that shall not exceed 10 business days if the
14 insurer or health maintenance organization has not received
15 requested information from a health care facility or health
16 professional.
17 (*l*) That a determination will be made by the insurer or health
18 maintenance organization not later than 72 hours after receipt of
19 an expedited grievance. Within 10 days after receipt of a
20 determination, the insured or enrollee may request a determination
21 of the matter by the commissioner or his or her designee or by an
22 independent review organization under the patient's right to
23 independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If
24 the determination by the insurer or health maintenance organization
25 is made orally, the insurer or health maintenance organization
26 shall provide a written confirmation of the determination to the
27 insured or enrollee not later than 2 business days after the oral

1 determination. An expedited grievance under this subdivision
2 applies if a grievance is submitted and a physician, orally or in
3 writing, substantiates that the time frame for a grievance under
4 subdivision (k) would seriously jeopardize the life or health of
5 the insured or enrollee or would jeopardize the insured's or
6 enrollee's ability to regain maximum function.
7 (m) That the insured or enrollee has the right to a
8 determination of the matter by the commissioner or his or her
9 designee or by an independent review organization under the
10 patient's right to independent review act, 2000 PA 251, MCL
11 550.1901 to 550.1929.
12 (2) An insured or enrollee may authorize in writing any
13 person, including, but not limited to, a physician, to act on his
14 or her behalf at any stage in a grievance proceeding under this
15 section.
16 (3) This section does not apply to a provider's complaint
17 concerning claims payment, handling, or reimbursement for health
18 care services.
19 (4) This section does not apply to a policy, certificate,
20 care, coverage, or insurance listed in section 5(2) of the
21 patient's right to independent review act, 2000 PA 251, MCL
22 550.1905, as not being subject to the patient's right to
23 independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.
24 (5) As used in this section:
25 (a) "Adverse determination" means a determination that an
26 admission, availability of care, continued stay, or other health
27 care service has been reviewed and denied, reduced, or terminated.

1 Failure to respond in a timely manner to a request for a
2 determination constitutes an adverse determination.
3 (b) "Grievance" means a complaint on behalf of an insured or
4 enrollee submitted by an insured or enrollee concerning any of the
5 following:
6 (*i*) The availability, delivery, or quality of health care
7 services, including a complaint regarding an adverse determination
8 made pursuant to utilization review.
9 (*ii*) Benefits or claims payment, handling, or reimbursement for
10 health care services.
11 (*iii*) Matters pertaining to the contractual relationship between
12 an insured or enrollee and the insurer or health maintenance
13 organization.