Act No. 517
Public Acts of 1996
Approved by the Governor
January 12, 1997
Filed with the Secretary of State
January 13, 1997

STATE OF MICHIGAN
88TH LEGISLATURE
REGULAR SESSION OF 1996

Introduced by Reps. Jamian, Gubow, Horton, Profit, Hill, Dolan, Rocca, Kukuk, Baird, Jellema, Goschka, Crissman, Freeman, Harder, Gire, Curtis, DeHart, Pitoniak, Yokich, Weeks, LeTarte, Hertel, Baade, Green, Rhead, McManus, Fitzgerald, Alley, Schroer, Bankes, Cherry, Middleton, Gustafson, Lowe, Wetters, Galloway, Brater, Walberg, Bodem, Llewellyn and Gernaat

Reps. Agee, Anthony, Bennane, Berman, Brackenridge, Brewer, Bush, Byl, Ciaramitaro, Clack, Cropsey, Dalman, DeLange, DeMars, Dobb, Dobronski, Emerson, Gagliardi, Geiger, Gilmer, Gnodtke, Griffin, Hammerstrom, Hanley, Jersevic, Kelly, Kilpatrick, LaForge, London, Martinez, Mathieu, McBryde, McNutt, Middaugh, Murphy, Nye, Olshove, Owen, Oxender, Palamara, Parks, Perricone, Porreca, Price, Prusi, Randall, Ryan, Scott, Sikkema, Tesanovich, Varga, Vaughn, Voorhees, Wallace, Whyman and Willard named co-sponsors

ENROLLED HOUSE BILL No. 5572

AN ACT to amend Act No. 218 of the Public Acts of 1956, entitled as amended "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to provide for the imposition of regulatory fees on certain insurers; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers,

duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to repeal certain acts and parts of acts; to repeal certain acts and parts of acts on specific dates; to repeal certain parts of this act on specific dates; and to provide penalties for the violation of this act," as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws, by adding sections 2212a, 2213, 2213a, 2213b, and 3406f.

The People of the State of Michigan enact:

Section 1. Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws, is amended by adding sections 2212a, 2213, 2213a, 2213b, and 3406f to read as follows:

Sec. 2212a. (1) By October 1, 1997, an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate issued under chapter 34 or 36 shall provide a written form in plain English to insureds upon enrollment that describes the terms and conditions of the insurer's policies and certificates. The form shall provide a clear, complete, and accurate description of all of the following as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of the insured's financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment in the event a provider's participation terminates during the course of an insured person's treatment by that provider.

(g) The telephone number to call to receive information concerning grievance procedures.

(h) A summary listing of the information available pursuant to subsection (2).

(2) By October 1, 1997, an insurer shall provide upon request to insureds covered under a policy or certificate issued under section 3405 or 3631 a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the policy or certificate's service area, including names and locations of participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.

(b) The professional credentials of participating health professionals, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the health professional presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the Michigan department of consumer and industry services that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the immediately preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if applicable, by specific service, benefit, or type of drug.

(e) Indication of the financial relationships between the insurer and any closed provider panel including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

(f) A telephone number and address to obtain from the insurer additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) shall be provided in writing. An insurer may require that a request under subsection (2) be submitted in writing.

Sec. 2213. (1) By October 1, 1997, 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.

(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 a written notification of the grievance procedures will be provided to the insured person when the insured person contests an adverse determination.

(*l*) That a final determination will be made in writing by the insurer not later than 90 calendar days after a formal grievance is submitted in writing by the insured person. The timing for the 90-calendar-day period may be tolled, however, for any period of time the insured person is permitted to take under the grievance procedure.

(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*) would acutely jeopardize the life of the insured.

(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, and is not appealable under Act No. 306 of the Public Acts of 1969.

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

(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:

(*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.

Sec. 2213a. All actual and necessary expenses incurred by the commissioner or the insurance bureau under section 2213 shall be calculated by the commissioner by June 30 of each year for the immediately preceding fiscal year. The commissioner shall divide these expenses among all insurers who issue a policy or certificate under chapter 34 or 36 in this state on a pro rata basis according to the direct written premiums reported in each insurer's annual statement for the immediately preceding calendar year by each of those insurers. This assessment shall be paid within 30 days after receipt of the assessment and is in addition to the regulatory fee provided for in section 224.

Sec. 2213b. (1) Except as provided in this section, an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical individual policy under chapter 34 shall renew or continue in force the policy at the option of the individual.

(2) Except as provided in this section, an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical group policy or certificate under chapter 36 shall renew or continue in force the policy or certificate at the option of the sponsor of the plan.

(3) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the insurer no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

Sec. 3406f. (1) An insurer may exclude or limit coverage for a condition as follows:

(a) For an individual covered under an individual policy or certificate or any other policy or certificate not covered under subdivision (b) or (c), only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

(b) For an individual covered under a group policy or certificate covering 2 to 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 12 months after the effective date of the policy or certificate.

(c) For an individual covered under a group policy or certificate covering more than 50 individuals, only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the policy or certificate.

(2) As used in this section, "group" means a group health plan as defined in section 2791(a)(1) and (2) of part C of title XXVII of the public health service act, chapter 373, 110 Stat. 1972, 42 U.S.C. 300gg-91, and includes government plans that are not federal government plans.

(3) This section applies only to an insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical policy or certificate. This section does not apply to any policy or certificate that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, long-term care, disability income, or 1-time limited duration policy or certificate of no longer than 6 months.

(4) The commissioner and the director of community health shall examine the issue of crediting prior continuous health care coverage to reduce the period of time imposed by preexisting condition limitations or exclusions under subsection (1)(a), (b), and (c) and shall report to the governor and the senate and the house of representatives standing committees on insurance and health policy issues by May 15, 1997. The report shall include the commissioner's and director's findings and shall propose alternative mechanisms or a combination of mechanisms to credit prior continuous health care coverage towards the period of time imposed by a preexisting condition limitation or exclusion. The report shall address at a minimum all of the following:

(a) Cost of crediting prior continuous health care coverages.

(b) Period of lapse or break in coverage, if any, permitted in a prior health care coverage.

(c) Types and scope of prior health care coverages that are permitted to be credited.

(d) Any exceptions or exclusions to crediting prior health care coverage.

(e) Uniform method of certifying periods of prior creditable coverage.

Section 2. This amendatory act shall take effect October 1, 1997.

This act is ordered to take immediate effect.

Clerk of the House of Representatives.

Secretary of the Senate.

Approved _____

Governor.