Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

SFA BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 1385 (Substitute S-1 as enrolled)
Sponsor: Senator Bill Bullard, Jr.
Committee: Financial Institutions

Date Completed: 10-7-02

RATIONALE

It has been suggested that disability income insurers should not be subject to the internal grievance procedure requirements that apply to other disability insurers and health maintenance organizations (HMOs). These requirements were added to the Insurance Code by Public Act 517 of 1996, as part of a package of legislation that imposed the same requirements on prudent purchaser organizations and Blue Cross and Blue Shield of Michigan. In general, this legislation requires a health insurer (or other source of health care coverage) to establish internal grievance procedures that enable patients to seek a review of a treatment decision or claim. The procedures must contain provisions specified in statute, and be approved by the Commissioner of the Office of Financial and Insurance Services.

Disability insurers are governed by Chapters 34 and 36 of the Insurance Code. Under the Code, disability insurance refers to a policy or contract insuring against loss resulting from sickness or from bodily injury or death by accident, including specific hospital benefits and medical, surgical, and sick-care benefits. The Code does not contain provisions specific to disability *income* insurers, whose policies provide for the replacement of income when an insured individual is injured. Since disability income insurers do not provide health insurance, their claims do not require them to make decisions about medical treatment or provider options in most circumstances.

When a insured person makes a claim under a disability income policy, the insurer must determine only whether the claim is valid and the amount that must be paid to replace the person's income. If the person disagrees with the company's decision, the dispute typically involves how much the person should be paid or when he or she should return to work. Since they therefore are not involved in medical treatment decisions, disability income insurers believe that the internal grievance procedures required of health care insurers are not appropriate for disability income insurance. It has been suggested that separate internal grievance requirements applicable only to disability income insurers should be established.

CONTENT

The bill would amend provisions of the Insurance Code concerning insurers' internal grievance procedures, to do the following:

-- Specify that the section requiring insurers and HMOs to establish internal grievance procedures would not apply to a policy or coverage that is exempt from the Patient's Right to Independent Review Act (PRIRA).
-- Specify that the section requiring insurers to pay the State's expenses incurred under the internal grievance procedure requirements, would not apply to a policy or coverage exempt from PRIRA.
-- Require disability income insurers to establish internal grievance procedures.

Exceptions

Section 2213 of the Code requires each insurer and HMO to establish an internal formal grievance procedure for people covered under a policy, certificate, or contract issued

under Chapter 34, 35, or 36 of the Code. (Chapters 34, 35, and 36 govern disability insurance policies, HMOs, and group and blanket disability insurance, respectively.)

Under the bill, Section 2213 would not apply to a policy, certificate, care, coverage, or insurance listed in Section 5(2) of the Patient's Right to Independent Review Act as not being subject to that Act. (Section 5(2) states that PRIRA does not apply to a policy or certificate that provides coverage only for specified accident or accident-only coverage, credit, disability income, hospital indemnity, disease, dental, vision care, or care provided pursuant to a system of health care delivery and financing operating under Section 3573 of the Code (which pertains to systems that are similar to HMOs), Medicare supplement policy, 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 (which provides for medical and dental care for members of the armed forces and their dependents), any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault.)

Section 2213a requires the Commissioner to calculate all actual and necessary expenses incurred by him or her or the Insurance Bureau (now within the Office of Financial and Insurance Services) under Section 2213. The Commissioner must make this calculation by June 30 each year for the preceding fiscal year. The Commissioner then must divide these expenses among all insurers that 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 preceding calendar year. The assessment must be paid within 30 days after its receipt.

Under the bill, Section 2213a would not apply to a policy, certificate, care, coverage, or insurance listed in Section 5(2) of the Patient's Right to Independent Review Act. The bill also would delete the reference to the Insurance Bureau.

Disability Income Insurer

The bill would require each disability income insurer to establish an internal grievance procedure for people covered under a disability income policy, certificate, or contract. As used in these provisions, "grievance" would mean a written complaint by an insured concerning the payment of benefits under a disability income insurance policy.

The procedure would have to provide for a designated person responsible for administering the procedure and a designated person or telephone number for receiving grievances; ensure full investigation of a grievance; provide for the insured's right to have the grievance reviewed by a managerial-level person or group; provide for timely notification to the insured of the progress and results of an investigation; and, if the insurer upheld its prior determination on the grievance, provide for advising the insured of his or her right to present the grievance to the Commissioner for review.

The procedure also would have to provide that the insurer would make a final written determination within 45 calendar days after the insured submitted a written grievance, unless the insurer required an extension of time to obtain additional information in order to make a determination with respect to the subject of the grievance. The extension could not exceed 45 days from the end of the initial period unless that period was extended because the insured failed to submit information necessary to decide the claim on appeal. In that case, the period for making the determination would have to be tolled (suspended) until the date the insured responded to the request for additional information.

In addition, the procedure would have to provide for copies of all grievances and responses to be available at the insurer's principal office for inspection by the Commissioner for two years after the year grievances were filed.

MCL 500.2213 et al.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Fiscal Analyst: Maria Tyszkiewicz

The internal grievance procedure requirements enacted in 1996 are part of a package of legislation known as the "patient's bill of rights". This legislation grew out of widespread dissatisfaction with so-called managed care plans, which restrict access to health care services and products, and often involve administrative officials in treatment decisions. Critics of managed care plans contend, among other things, that patients sometimes are denied medically necessary treatment, or coverage for treatment. When the patient's bill of rights was enacted in 1996, its supporters felt that well informed consumers with access to formal internal grievance procedures would lead to better-performing health benefit plans and less overall dissatisfaction. This legislation was followed in 2000 by the Patient's Right to Independent Review Act, which established a uniform external appeals process for all health carriers.

Although disability income insurers already are exempt from PRIRA, they are subject to the internal grievance procedure requirements contained in the Insurance Code. The managed care problems that led to the patient's bill of rights, however, do not apply to disability income insurance, since that type of coverage does not involve medical treatment decisions. Therefore, it would make sense to establish separate grievance procedures for disability income insurers. Far less detailed than existing requirements, the bill would create a more appropriate process for the resolution of disputes between injured individuals and their disability income insurers. The proposal also would ensure that insured people were informed of their right to have the Commissioner review a grievance.

Reportedly, no one has used the existing grievance procedures to address a disability income dispute. This may be because people associate those procedures with medical coverage and are not aware that they apply to disability income insurance. By requiring a grievance procedure specific to this insurance, the bill would create another avenue for the resolution of disputes that otherwise could result in litigation.

Legislative Analyst: Suzanne Lowe

FISCAL IMPACT

The bill would have no fiscal impact on State or local government.

A0102\s1385a