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SFA BILL ANALYSIS

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

Date Completed: 9-24-02

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 health maintenance organizations (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.
-- 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 the Patient's Right to Independent Review Act.
-- Provide for the right of insured people or enrollees to have their grievance reviewed, or to have the matter determined, by the Commissioner of the Office of Financial and Insurance Services or by an independent review organization.
-- 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.) The procedure must be approved by the Commissioner and contain provisions specified in the Code.

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 the Patient's Right to Independent Review Act 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.

Review by Commissioner

Under the Code, an insured or enrollee had a right to a review of the grievance, and a determination of the matter, by the Commissioner through September 30, 2000. Since October 1, 2000, an insured or enrollee has had a right to a review and determination by an independent review organization. An insurer's or HMO's grievance procedure must notify the insured or enrollee of this right to review, and provide for the right to a determination.

Under the bill, a grievance procedure would have to provide for notification to the insured or enrollee of his or her right to a review of the grievance by the Commissioner or by an independent review organization, and would have to provide for the right of the insured or enrollee to a determination of the matter by the Commissioner or his or her designee or by an independent review organization.

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. Legislative Analyst: Suzanne Lowe

FISCAL IMPACT

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

Fiscal Analyst: Maria Tyszkiewicz

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