SUBSTITUTE FOR

SENATE BILL NO. 1385

(As passed the Senate, November 13, 2002)

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending sections 2213 and 2213a (MCL 500.2213 and 500.2213a), section 2213 as amended by 2000 PA 252 and section 2213a as added by 1996 PA 517, and by adding section 2213c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 2213. (1) ~~Each~~ EXCEPT AS OTHERWISE PROVIDED IN SUB-
2 SECTION (4), EACH insurer and health maintenance organization
3 shall establish an internal formal grievance procedure for
4 approval by the commissioner for persons covered under a policy,
5 certificate, or contract issued under chapter 34, 35, or 36 that
6 includes all of the following:
7 (a) Provides for a designated person responsible for
8 administering the grievance system.

1 (b) Provides a designated person or telephone number for
2 receiving complaints.
3 (c) Ensures full investigation of a complaint.
4 (d) Provides for timely notification in plain English to the
5 insured or enrollee as to the progress of an investigation.
6 (e) Provides an insured or enrollee the right to appear
7 before the board of directors or designated committee or the
8 right to a managerial-level conference to present a grievance.
9 (f) Provides for notification in plain English to the
10 insured or enrollee of the results of the insurer's or health
11 maintenance organization's investigation and for advisement of
12 the insured's or enrollee's right to review the grievance by the
13 commissioner ~~through September 30, 2000 and beginning October 1,~~
14 ~~2000~~ OR by an independent review organization under the
15 patient's right to independent review act, 2000 PA 251,
16 MCL 550.1901 TO 550.1929.
17 (g) Provides summary data on the number and types of com-
18 plaints and grievances filed. Beginning April 15, 2001, this
19 summary data for the prior calendar year shall be filed annually
20 with the commissioner on forms provided by the commissioner.
21 (h) Provides for periodic management and governing body
22 review of the data to assure that appropriate actions have been
23 taken.
24 (i) Provides for copies of all complaints and responses to
25 be available at the principal office of the insurer or health
26 maintenance organization for inspection by the commissioner for 2
27 years following the year the complaint was filed.

1 (j) That when an adverse determination is made, a written
2 statement in plain English containing the reasons for the adverse
3 determination is provided to the insured or enrollee along with
4 written notifications as required under the patient's right to
5 independent review act, 2000 PA 251, MCL 550.1901 TO 550.1929.
6 (k) That a final determination will be made in writing by
7 the insurer or health maintenance organization not later than 35
8 calendar days after a formal grievance is submitted in writing by
9 the insured or enrollee. The timing for the 35-calendar-day
10 period may be tolled, however, for any period of time the insured
11 or enrollee is permitted to take under the grievance procedure
12 and for a period of time that shall not exceed 10 business days
13 if the insurer or health maintenance organization has not
14 received requested information from a health care facility or
15 health professional.
16 (*l*) That a determination will be made by the insurer or
17 health maintenance organization not later than 72 hours after
18 receipt of an expedited grievance. Within 10 days after receipt
19 of a determination, the insured or enrollee may request a deter-
20 mination of the matter by the commissioner or his or her designee
21 ~~through September 30, 2000 and beginning October 1, 2000~~ OR by
22 an independent review organization under the patient's right to
23 independent review act, 2000 PA 251, MCL 550.1901 TO 550.1929.
24 If the determination by the insurer or health maintenance organi-
25 zation is made orally, the insurer or health maintenance organi-
26 zation shall provide a written confirmation of the determination
27 to the insured or enrollee not later than 2 business days after

1 the oral determination. An expedited grievance under this
2 subdivision applies if a grievance is submitted and a physician,
3 orally or in writing, substantiates that the time frame for a
4 grievance under subdivision (k) would seriously jeopardize the
5 life or health of the insured or enrollee or would jeopardize the
6 insured's or enrollee's ability to regain maximum function.

7 (m) That the insured or enrollee has the right to a determi-
8 nation of the matter by the commissioner or his or her designee
9 ~~through September 30, 2000 and beginning October 1, 2000~~ OR by
10 an independent review organization under the patient's right to
11 independent review act, 2000 PA 251, MCL 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,
22 MCL 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) ~~(4)~~ 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

1 terminated. Failure to respond in a timely manner to a request
2 for a 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
5 the following:
6 (*i*) The availability, delivery, or quality of health care
7 services, including a complaint regarding an adverse determina-
8 tion made pursuant to utilization review.
9 (*ii*) Benefits or claims payment, handling, or reimbursement
10 for health care services.
11 (*iii*) Matters pertaining to the contractual relationship
12 between an insured or enrollee and the insurer or health mainte-
13 nance organization.
14 Sec. 2213a. (1) All actual and necessary expenses incurred
15 by the commissioner ~~or the insurance bureau~~ under section 2213
16 shall be calculated by the commissioner by June 30 of each year
17 for the immediately preceding fiscal year. ~~The~~ EXCEPT AS OTH-
18 ERWISE PROVIDED IN SUBSECTION (2), THE commissioner shall divide
19 these expenses among all insurers who issue a policy or certifi-
20 cate under chapter 34 or 36 in this state on a pro rata basis
21 according to the direct written premiums reported in each
22 insurer's annual statement for the immediately preceding calendar
23 year by each of those insurers. This assessment shall be paid
24 within 30 days after receipt of the assessment and is in addition
25 to the regulatory fee provided for in section 224.
26 (2) THIS SECTION DOES NOT APPLY TO A POLICY, CERTIFICATE,
27 CARE, COVERAGE, OR INSURANCE LISTED IN SECTION 5(2) OF THE

1 PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT, 2000 PA 251,
2 MCL 550.1905, AS NOT BEING SUBJECT TO THE PATIENT'S RIGHT TO
3 INDEPENDENT REVIEW ACT, 2000 PA 251, MCL 550.1901 TO 550.1929.
4 SEC. 2213C. (1) EACH DISABILITY INCOME INSURER SHALL ESTAB-
5 LISH AN INTERNAL GRIEVANCE PROCEDURE FOR PERSONS COVERED UNDER A
6 DISABILITY INCOME POLICY, CERTIFICATE, OR CONTRACT.
7 (2) AN INTERNAL GRIEVANCE PROCEDURE UNDER SUBSECTION (1)
8 SHALL INCLUDE ALL OF THE FOLLOWING:
9 (A) PROVIDE FOR A DESIGNATED PERSON RESPONSIBLE FOR ADMINIS-
10 TERING THE GRIEVANCE PROCEDURE.
11 (B) PROVIDE FOR A DESIGNATED PERSON OR TELEPHONE NUMBER FOR
12 RECEIVING GRIEVANCES.
13 (C) ENSURE FULL INVESTIGATION OF A GRIEVANCE.
14 (D) PROVIDE FOR TIMELY NOTIFICATION TO THE INSURED AS TO THE
15 PROGRESS OF AN INVESTIGATION.
16 (E) PROVIDE FOR THE INSURED TO HAVE THE RIGHT TO HAVE THE
17 GRIEVANCE REVIEWED BY A MANAGERIAL-LEVEL PERSON OR GROUP.
18 (F) PROVIDE FOR NOTIFICATION TO THE INSURED OF THE RESULTS
19 OF THE INSURER'S INVESTIGATION AND, IF THE INSURER UPHOLDS ITS
20 PRIOR DETERMINATION ON THE GRIEVANCE, FOR ADVISING THE INSURED OF
21 HIS OR HER RIGHT TO PRESENT THE GRIEVANCE TO THE COMMISSIONER FOR
22 REVIEW.
23 (G) PROVIDE THAT A FINAL DETERMINATION WILL BE MADE IN WRIT-
24 ING BY THE INSURER NOT LATER THAN 45 CALENDAR DAYS AFTER A GRIEV-
25 ANCE IS SUBMITTED IN WRITING BY THE INSURED UNLESS THE INSURER
26 REQUIRES AN EXTENSION OF TIME TO OBTAIN ADDITIONAL INFORMATION TO
27 MAKE A DETERMINATION WITH RESPECT TO THE SUBJECT OF THE

1 GRIEVANCE. THE EXTENSION MAY NOT EXCEED 45 DAYS FROM THE END OF
2 THE INITIAL PERIOD UNLESS THE INITIAL PERIOD IS EXTENDED DUE TO
3 THE INSURED'S FAILURE TO SUBMIT INFORMATION NECESSARY TO DECIDE
4 THE CLAIM ON APPEAL. IF THE EXTENSION IS DUE TO AN INSURED'S
5 FAILURE TO SUBMIT INFORMATION, THE PERIOD FOR MAKING THE DETERMI-
6 NATION SHALL BE TOLLED UNTIL THE DATE THE INSURED RESPONDS TO THE
7 REQUEST FOR ADDITIONAL INFORMATION.
8 (H) PROVIDE FOR COPIES OF ALL GRIEVANCES AND RESPONSES TO BE
9 AVAILABLE AT THE PRINCIPAL OFFICE OF THE INSURER FOR INSPECTION
10 BY THE COMMISSIONER FOR 2 YEARS FOLLOWING THE YEAR THE GRIEVANCE
11 WAS FILED.
12 (3) AS USED IN THIS SECTION, "GRIEVANCE" MEANS A WRITTEN
13 COMPLAINT BY AN INSURED CONCERNING THE PAYMENT OF BENEFITS UNDER
14 A DISABILITY INCOME INSURANCE POLICY.