Act No. 707
Public Acts of 2002
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STATE OF MICHIGAN
91ST LEGISLATURE
REGULAR SESSION OF 2002

Introduced by Senator Bullard

ENROLLED SENATE BILL No. 1385

AN ACT to amend 1956 PA 218, entitled "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 provide for assessment fees on certain health maintenance organizations; 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 regulation over worker's compensation self-insurers; 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 provide for an appropriation; to repeal acts and parts of acts; and to provide penalties for the violation of this act," 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:

Sec. 2213. (1) Except as otherwise provided in subsection (4), each insurer and health maintenance organization shall establish an internal formal grievance procedure for approval by the commissioner for persons covered under a policy, certificate, or contract issued under chapter 34, 35, 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 in plain English to the insured or enrollee as to the progress of an investigation.

(e) Provides an insured or enrollee 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 in plain English to the insured or enrollee of the results of the insurer's or health maintenance organization's investigation and for advisement of the insured's or enrollee's right to review the grievance 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 summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the commissioner on forms provided by the commissioner.

(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 or health maintenance organization for inspection by the commissioner for 2 years following the year the complaint was filed.

(j) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer or health maintenance organization not later than 35 calendar days after a formal grievance is submitted in writing by the insured or enrollee. The timing for the 35-calendar-day period may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if the insurer or health maintenance organization has not received requested information from a health care facility or health professional.

(*l*) That a determination will be made by the insurer or health maintenance organization not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer or health maintenance organization is made orally, the insurer or health maintenance organization shall provide a written confirmation of the determination to the insured or enrollee 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 (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the commissioner or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

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

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) 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, reduced, or terminated. 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 or enrollee submitted by an insured or enrollee concerning any of the following:

(*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 or enrollee and the insurer or health maintenance organization.

Sec. 2213a. (1) All actual and necessary expenses incurred by the commissioner under section 2213 shall be calculated by the commissioner by June 30 of each year for the immediately preceding fiscal year. Except as otherwise provided in subsection (2), 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.

(2) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

Sec. 2213c. (1) Each disability income insurer shall establish an internal grievance procedure for persons covered under a disability income policy, certificate, or contract.

(2) An internal grievance procedure under subsection (1) shall include all of the following:

(a) Provide for a designated person responsible for administering the grievance procedure.

(b) Provide for a designated person or telephone number for receiving grievances.

(c) Ensure full investigation of a grievance.

(d) Provide for timely notification to the insured as to the progress of an investigation.

(e) Provide for the insured to have the right to have the grievance reviewed by a managerial-level person or group.

(f) Provide for notification to the insured of the results of the insurer's investigation and, if the insurer upholds its prior determination on the grievance, for advising the insured of his or her right to present the grievance to the commissioner for review.

(g) Provide that a final determination will be made in writing by the insurer not later than 45 calendar days after a grievance is submitted in writing by the insured unless the insurer requires an extension of time to obtain additional information to make a determination with respect to the subject of the grievance. The extension may not exceed 45 days from the end of the initial period unless the initial period is extended due to the insured's failure to submit information necessary to decide the claim on appeal. If the extension is due to an insured's failure to submit information, the period for making the determination shall be tolled until the date the insured responds to the request for additional information.

(h) Provide for copies of all grievances and responses to be available at the principal office of the insurer for inspection by the commissioner for 2 years following the year the grievance was filed.

(3) As used in this section, "grievance" means a written complaint by an insured concerning the payment of benefits under a disability income insurance policy.

This act is ordered to take immediate effect.

Carol Morey Viventi

Secretary of the Senate.

Clerk of the House of Representatives.

Approved _____

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Governor.