THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.5208a Definitions; prohibited conduct; probable cause of violation; notice of hearing; opportunity to confer and discuss complaint and proceedings; action for damages; hearing; findings and decision; cease and desist order; processing claims for benefits; interest; claim form; service contract provisions; violation of section; penalties; severability.

Sec. 5208a.

(1) As used in this section:

(a) "Noninsured benefit plan" means a benefit plan without insurance or the noninsured portion of a benefit plan which has specific or aggregate excess loss insurance.

(b) "Process a claim" means the services performed in connection with a claim for benefits including the disbursement of benefit amounts.

(2) An insurer providing services under section 5208 in connection with a noninsured benefit plan, with respect to such services, shall not do any of the following:

(a) Misrepresent pertinent facts relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim for benefits.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim for benefits.

(d) Refuse to process claims without conducting a reasonable investigation based upon the available information.

(e) Fail to communicate affirmation or denial of coverage of a claim for benefits within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to promptly, fairly, and equitably process a claim for benefits.

(g) Knowingly compel covered individuals to institute litigation to recover amounts due under a benefit plan by offering substantially less than the amounts due.

(h) For the purpose of coercing a covered individual to accept a settlement or compromise in a claim, inform the covered individual of a policy of appealing administrative hearing decisions which are in favor of covered individuals.

(i) Delay the investigation or processing of a claim by requiring a covered individual, or the provider of services to the covered individual, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(j) Fail to promptly provide a reasonable explanation of the basis for denial or partial denial of a claim for benefits.

(k) Fail to promptly process a claim where liability has become reasonably clear under 1 portion of a benefit plan in order to influence a settlement under another portion of the benefit plan.

(l) Refuse to enter into a service contract nor refuse to provide services under a service contract because of race, color, creed, marital status, sex, national origin, residence, age, disability, or lawful occupation.

(3) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall not, in order to induce a person to contract or to continue to contract with the insurer for the provision of services under a service contract offered by the insurer; to induce a person to lapse, forfeit, or surrender a policy or service contract issued by the insurer; or to induce a person to secure or terminate coverage with another insurer, health care corporation, health maintenance organization, or other person, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a service contract other than as plainly expressed in the service contract.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or adjustment of the rate payable on the service contract, or an advantage in the services thereunder, except as reflected in the rate and expressly provided in the service contract. Readjustment of the rate for services provided under the service contract may be made at the end of any contract year or contract period and may be made retroactive.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a service contract, the advantages provided thereunder, or the true nature thereof.

(e) Make a misrepresentation in a comparison, whether oral or written, between service contracts of the insurer or between service contracts of the insurer and another insurer, health care corporation, health maintenance organization, or other person.

(4) When the commissioner has probable cause to believe that an insurer is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that an insurer is violating or has violated subsection (3), he or she shall give written notice to the insurer,

pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, setting forth the general nature of the complaint against the insurer and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the insurer an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(5) A hearing held pursuant to subsection (4) shall be held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328. If, after the hearing, the commissioner determines that the insurer is violating, or has violated subsection (2), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has violated or is violating subsection (3), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the insurer a copy of the findings and an order requiring the insurer to cease and desist from engaging in the prohibited activity. The commissioner may at any time, by order, and after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, when in his or her opinion conditions of fact or law have so changed as to require that action, or if the public interest so requires.

(6) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall process claims for benefits on a timely basis. When not paid on a timely basis, benefits payable to a covered individual shall bear simple interest from a date 60 days after a satisfactory claim form was received by the insurer, at a rate of 12% interest per annum. The interest shall be paid by the noninsured benefit plan in addition to, and at the time of payment of, the claim.

(7) An insurer providing services under section 5208 in connection with a noninsured benefit plan shall specify in writing the materials which constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the insurer.

(8) An insurer providing the services under section 5208 in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual what services are being provided; the fact that individuals are not insured or are only partially insured, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(9) An insurer which violates this section shall be subject to the same penalties as provided in section 2038.

(10) The sections and subsections of this act are declared to be severable and if any court of competent jurisdiction finds that any section or subsection is invalid, the remaining sections or subsections shall remain in full force and effect.

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