SUBSTITUTE FOR

SENATE BILL NO. 694

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending section 2006 (MCL 500.2006).

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2006. (1) A person must pay on a timely basis to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant the benefits provided under the terms of its policy, or, in the alternative, the person must pay to its insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant 12% interest, as provided in subsection (4), on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims as provided in subsection (4) is an unfair trade practice unless the claim is reasonably in dispute.

(2) A person shall not be found to have committed an unfair trade practice under this section if the person is found liable for a claim pursuant to a judgment rendered by a court of law, and the person pays to its insured, individual or entity directly entitled to benefits under its insured's contract of insurance, or third party tort claimant interest as provided in subsection (4).

(3) An insurer shall specify in writing the materials ~~which~~ THAT constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss shall be ~~deemed to be~~ CONSIDERED paid on a timely basis if paid within 60 days after receipt of proof of loss by the insurer. Any part of the remainder of the claim that is later supported by proof of loss shall be ~~deemed to be~~ CONSIDERED paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. ~~Where~~ IF the proof of loss provided by the claimant contains facts ~~which~~ THAT clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim shall be ~~deemed to be~~ CONSIDERED paid on a timely basis if paid within 60 days after receipt of necessary medical information by the insurer. Payment of a claim shall not be untimely during any period in which the insurer is unable to pay the claim when there is no recipient who is legally able to give a valid release for the payment, or where the insurer is unable to determine who is

entitled to receive the payment, if the insurer has promptly notified the claimant of that inability and has offered in good faith to promptly pay the claim upon determination of who is entitled to receive the payment.

(4) ~~When~~ IF benefits are not paid on a timely basis the benefits paid shall bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or an individual or entity directly entitled to benefits under the insured's contract of insurance. ~~Where~~ IF the claimant is a third party tort claimant, then the benefits paid shall bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, ~~and~~ the insurer has refused payment in bad faith ~~,~~ ~~such~~ AND THE bad faith ~~having been~~ WAS determined by a court of law. The interest shall be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest shall be payable based upon the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest ~~shall~~ IS not ~~be~~ due. Interest paid pursuant to this section shall be offset by any award of interest that is payable by the insurer pursuant to the award.

(5) ~~Where~~ IF a person contracts to provide benefits and reinsures all or a portion of the risk, the person contracting to provide benefits ~~shall be~~ IS liable for interest due to an insured, an individual or entity directly entitled to benefits under its insured's contract of insurance, or a third party tort claimant under this section where a reinsurer fails to pay benefits on a timely basis.

(6) ~~In the event of~~ IF THERE IS any specific inconsistency between this section and ~~the provisions of Act No. 294 of the Public Acts of 1972, as amended, being sections 500.3101 to 500.3177 of the Compiled Laws of 1970 or of the provisions of Act No. 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Compiled Laws of 1970,~~ SECTIONS 3101 TO 3177 OR THE WORKER'S DISABILITY COMPENSATION ACT OF 1969, 1969 PA 317, MCL 418.101 TO 418.941, the provisions of this section ~~shall~~ DO not apply. SUBSECTIONS (7) TO (12) DO NOT APPLY TO AN ENTITY REGULATED UNDER THE WORKER'S DISABILITY COMPENSATION ACT OF 1969, 1969 PA 317, MCL 418.101 TO 418.941.

(7) SUBSECTIONS (1) TO (6) DO NOT APPLY AND SUBSECTIONS (8) TO (12) DO APPLY TO HEALTH PLANS WHEN PAYING CLAIMS TO HEALTH PROFESSIONALS AND FACILITIES THAT DO NOT INVOLVE CLAIMS ARISING OUT OF SECTIONS 3101 TO 3177 OR THE WORKER'S DISABILITY COMPENSATION ACT OF 1969, 1969 PA 317, MCL 418.101 TO 418.941.

(8) THE COMMISSIONER OF INSURANCE SHALL ESTABLISH A TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE TO BE USED BY HEALTH PROFESSIONALS AND FACILITIES IN BILLING FOR, AND HEALTH PLANS IN PROCESSING AND PAYING CLAIMS FOR, SERVICES RENDERED. THE

COMMISSIONER SHALL CONSULT WITH THE DEPARTMENT OF COMMUNITY HEALTH, HEALTH PROFESSIONALS AND FACILITIES, AND HEALTH PLANS IN ESTABLISHING THIS TIMELY PAYMENT PROCEDURE.

(9) THE TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE ESTABLISHED BY THE COMMISSIONER UNDER SUBSECTION (8) SHALL PROVIDE FOR ALL OF THE FOLLOWING:

(A) THAT A "CLEAN CLAIM", FOR THE PURPOSES OF THIS SECTION, MEANS A CLAIM THAT DOES AT A MINIMUM ALL OF THE FOLLOWING:

(*i*) IDENTIFIES THE HEALTH PROFESSIONAL OR HEALTH FACILITY THAT PROVIDED TREATMENT OR SERVICE, INCLUDING A MATCHING IDENTIFYING NUMBER.

(*ii*) IDENTIFIES THE PATIENT AND HEALTH PLAN SUBSCRIBER.

(*iii*) LISTS THE DATE AND PLACE OF SERVICE.

(*iv*) IS FOR COVERED SERVICES.

(*v*) IF NECESSARY, SUBSTANTIATES THE MEDICAL NECESSITY AND APPROPRIATENESS OF THE CARE OR SERVICE PROVIDED.

(*vi*) IF PRIOR AUTHORIZATION IS REQUIRED FOR CERTAIN PATIENT CARE OR SERVICES, INCLUDES THE AUTHORIZATION NUMBER.

(*vii*) INCLUDES ADDITIONAL DOCUMENTATION BASED UPON SERVICES RENDERED AS REASONABLY REQUIRED BY THE HEALTH PLAN.

(B) A UNIVERSAL SYSTEM OF CODING TO BE USED ON ALL CLAIMS SUBMITTED TO HEALTH PLANS. IF A UNIVERSAL CODING SYSTEM IS DEVELOPED BY THE FEDERAL GOVERNMENT, IT WILL BE USED IN PLACE OF THE CODING DEVELOPED PURSUANT TO THIS SECTION.

(C) THAT A CLAIM MUST BE TRANSMITTED ELECTRONICALLY OR AS OTHERWISE SPECIFIED BY THE COMMISSIONER AND A HEALTH PLAN MUST BE ABLE TO RECEIVE A CLAIM TRANSMITTED ELECTRONICALLY OR AS OTHERWISE SPECIFIED BY THE COMMISSIONER.

(D) THE NUMBER OF DAYS AFTER A SERVICE WAS PROVIDED WITHIN WHICH A HEALTH PROFESSIONAL AND FACILITY MUST BILL A HEALTH PLAN FOR THE CLAIM.

(E) THAT A CLEAN CLAIM MUST BE PAID WITHIN 45 DAYS AFTER RECEIPT OF THE CLAIM BY THE HEALTH PLAN. A CLEAN CLAIM THAT IS NOT PAID WITHIN 45 DAYS SHALL BEAR SIMPLE INTEREST AT A RATE OF 12% PER ANNUM.

(F) THAT A HEALTH PLAN MUST STATE IN WRITING TO THE HEALTH PROFESSIONAL OR FACILITY ANY DEFECT IN THE CLAIM WITHIN 30 DAYS AFTER RECEIPT OF THE CLAIM.

(G) THAT A HEALTH PROFESSIONAL AND A HEALTH FACILITY HAVE 30 DAYS AFTER RECEIPT OF A NOTICE THAT A CLAIM OR A PORTION OF A CLAIM IS DEFECTIVE WITHIN WHICH TO CORRECT THE DEFECT. THE HEALTH PLAN SHALL PAY THE CLAIM WITHIN 30 DAYS AFTER THE DEFECT IS CORRECTED.

(H) THAT A HEALTH PLAN MUST NOTIFY THE HEALTH PROFESSIONAL OR FACILITY OF THE DEFECT, IF A CLAIM OR A PORTION OF A CLAIM IS RETURNED FROM A HEALTH PROFESSIONAL OR FACILITY UNDER SUBDIVISION (G) AND REMAINS DEFECTIVE FOR THE ORIGINAL REASON OR A NEW REASON.

(I) THAT A HEALTH PLAN MUST REPORT TO THE COMMISSIONER THE NUMBER OF CLAIMS THAT HAVE NOT BEEN PAID WITHIN THE TIME LIMITS PRESCRIBED IN THIS SECTION. THE REPORT IS DUE ON JANUARY 1, APRIL

1, JULY 1, AND OCTOBER 1 OF EACH YEAR. HOWEVER, A REPORT IS NOT DUE DURING THE 6-MONTH PERIOD FOLLOWING THE EFFECTIVE DATE OF THE AMENDATORY ACT THAT ADDED THIS SUBDIVISION.

(J) PENALTIES TO BE APPLIED TO HEALTH PROFESSIONALS, HEALTH FACILITIES, AND HEALTH PLANS FOR FAILING TO ADHERE TO THE TIMELY CLAIMS PAYMENT PROCEDURE ESTABLISHED UNDER SUBSECTIONS (7) TO (12).

(K) THAT IF A HEALTH PLAN, HEALTH PROFESSIONAL, OR HEALTH FACILITY DISAGREES WITH THE PENALTY IMPOSED BY THE COMMISSIONER OR HIS OR HER DESIGNEE UNDER SUBDIVISION (J), THE COMMISSIONER OR HIS OR HER DESIGNEE SHALL PROCEED TO HEAR THE MATTER AS A CONTESTED CASE UNDER THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969 PA 306, MCL 24.201 TO 24.328.

(*l*) A SYSTEM FOR NOTIFYING THE LICENSING ENTITY IF A PENALTY IS INCURRED UNDER SUBDIVISION (J).

(10) IF A HEALTH PLAN DETERMINES THAT 1 OR MORE SERVICES LISTED ON A CLAIM ARE PAYABLE, THE HEALTH PLAN SHALL PAY FOR THOSE SERVICES AND SHALL NOT DENY THE ENTIRE CLAIM BECAUSE 1 OR MORE OTHER SERVICES LISTED ON THE CLAIM ARE DEFECTIVE. THIS SUBSECTION DOES NOT APPLY IF A HEALTH PLAN AND HEALTH PROFESSIONAL OR HEALTH FACILITY HAVE AN OVERRIDING CONTRACTUAL REIMBURSEMENT ARRANGEMENT.

(11) THE COMMISSIONER SHALL REPORT TO THE SENATE AND HOUSE OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE ISSUES BY OCTOBER 1, 2001 ON THE TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE ESTABLISHED UNDER SUBSECTIONS (7) TO (12).

(12) AS USED IN SUBSECTIONS (7) TO (11), "HEALTH PLAN" MEANS ALL OF THE FOLLOWING:

(A) AN INSURER PROVIDING BENEFITS UNDER AN EXPENSE-INCURRED HOSPITAL, MEDICAL, SURGICAL, VISION, OR DENTAL POLICY OR CERTIFICATE, INCLUDING ANY POLICY OR CERTIFICATE THAT PROVIDES COVERAGE FOR SPECIFIC DISEASES OR ACCIDENTS ONLY, OR ANY HOSPITAL INDEMNITY, MEDICARE SUPPLEMENT, LONG-TERM CARE, DISABILITY INCOME, OR 1-TIME LIMITED DURATION POLICY OR CERTIFICATE.

(B) A MEWA REGULATED UNDER CHAPTER 70 THAT PROVIDES HOSPITAL, MEDICAL, SURGICAL, VISION, DENTAL, AND SICK CARE BENEFITS.

(C) A HEALTH MAINTENANCE ORGANIZATION LICENSED OR ISSUED A CERTIFICATE OF AUTHORITY IN THIS STATE.

(D) A HEALTH CARE CORPORATION OPERATING UNDER THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704.

Enacting section 1. This amendatory act takes effect on January 1, 2001 and applies to all health care claims submitted for payment on and after January 1, 2001.