SENATE BILL No. 930

January 25, 2000, Introduced by Senators BYRUM, EMERSON and A. SMITH and referred to the Committee on Health Policy.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending the title and section 2006 (MCL 500.2006), the title as amended by 1998 PA 457, and by adding section 2006a.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

TITLE

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

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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 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 CERTAIN REGULATION OVER QUALIFIED HEALTH PLANS; 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 repeal acts and parts of acts; and to provide penalties for the violation of this act.

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~~ IS 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~~ IS 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~~ IS 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.

(7) THIS SECTION DOES NOT APPLY TO ANY OF THE FOLLOWING:

(A) BENEFITS PROVIDED UNDER AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL 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) HOSPITAL, MEDICAL, SURGICAL, VISION, DENTAL, AND SICK CARE BENEFITS PROVIDED BY A MEWA REGULATED UNDER CHAPTER 70.

SEC. 2006A. (1) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ACT, THIS SECTION APPLIES TO ALL OF THE FOLLOWING:

(A) BENEFITS PROVIDED UNDER AN EXPENSE-INCURRED HOSPITAL, MEDICAL OR SURGICAL 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) HOSPITAL, MEDICAL, SURGICAL, VISION, DENTAL, AND SICK CARE BENEFITS PROVIDED BY A MEWA REGULATED UNDER CHAPTER 70.

(C) BENEFITS PROVIDED UNDER A HEALTH MAINTENANCE ORGANIZATION CONTRACT.

(D) BENEFITS PROVIDED UNDER A HEALTH CARE CORPORATION CERTIFICATE.

(E) BENEFITS PROVIDED UNDER A QUALIFIED HEALTH PLAN.

(2) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (4), AN INSURER SHALL PAY IN FULL THE CLAIM PAYMENT AMOUNT FOR A HEALTH CARE CLAIM, OR ANY UNDISPUTED PART OF A HEALTH CARE CLAIM, AS FOLLOWS:

(A) WITHIN 30 DAYS FOLLOWING RECEIPT OF A CLEAN CLAIM BY ELECTRONIC TRANSMISSION.

(B) WITHIN 45 DAYS FOLLOWING RECEIPT OF A CLEAN CLAIM BY HARD COPY.

(3) A HEALTH CARE CLAIM SHALL BE CONSIDERED A CLEAN CLAIM, UNLESS AN INSURER, WITHIN 30 DAYS FOLLOWING RECEIPT OF A CLAIM BY ELECTRONIC TRANSMISSION OR WITHIN 45 DAYS FOLLOWING RECEIPT OF A CLAIM BY HARD COPY, REQUESTS IN WRITING FROM THE CLAIMANT ALL ADDITIONAL INFORMATION, IF ANY, REASONABLY NEEDED TO DETERMINE LIABILITY TO PAY THE HEALTH CARE CLAIM. UPON THE INSURER'S

RECEIPT OF ALL ADDITIONAL REQUESTED INFORMATION, THE HEALTH CARE CLAIM SHALL BE CONSIDERED A CLEAN CLAIM. AN INSURER THAT REQUESTS ADDITIONAL INFORMATION THAT IS NOT REASONABLY NEEDED TO DETERMINE LIABILITY TO PAY A HEALTH CARE CLAIM IS LIABLE FOR THE PAYMENT OF INTEREST AS PROVIDED IN SUBSECTION (8).

(4) AN INSURER SHALL PAY A CLEAN CLAIM WITHIN THE APPLICABLE 30- AND 45-DAY TIME PERIODS PRESCRIBED IN SUBSECTION (2)(A) AND (B) UNLESS THE INSURER REASONABLY DISPUTES ITS OBLIGATION TO PAY THE CLEAN CLAIM, IN WHOLE OR IN PART, BASED ON 1 OR MORE OF THE FOLLOWING GROUNDS:

(A) THE ELIGIBILITY OF A PERSON FOR COVERAGE.

(B) THE LIABILITY OF ANOTHER INSURER OR PERSON FOR ALL OR PART OF THE CLAIM.

(C) THE AMOUNT OF THE CLAIM.

(D) THE COVERED BENEFITS.

(E) THE MANNER IN WHICH SERVICES WERE ACCESSED OR PROVIDED.

(F) THAT THE CLAIM WAS SUBMITTED FRAUDULENTLY SO LONG AS THERE IS A REASONABLE BASIS SUPPORTED BY SPECIFIC INFORMATION AVAILABLE FOR REVIEW BY THE COMMISSIONER TO SUPPORT THIS BELIEF.

(5) FOLLOWING RECEIPT OF A CLEAN CLAIM AND WITHIN THE APPLICABLE 30- AND 45-DAY TIME PERIODS PRESCRIBED IN SUBSECTION (2)(A) AND (B), AN INSURER THAT DISPUTES ITS OBLIGATION TO PAY A CLEAN CLAIM, IN WHOLE OR IN PART, SHALL NOTIFY THE CLAIMANT IN WRITING THAT IT IS NOT OBLIGATED TO PAY SOME OR ALL OF THE CLAIM STATING WITH SPECIFICITY ALL REASONS WHY IT IS NOT LIABLE. AN INSURER THAT VIOLATES SUBSECTION (4) OR UNREASONABLY DISPUTES LIABILITY

TO PAY A CLAIM IS LIABLE FOR THE PAYMENT OF INTEREST AS PROVIDED IN SUBSECTION (8).

(6) EACH HEALTH CARE CLAIM PROCESSED IN VIOLATION OF THIS SECTION CONSTITUTES A SEPARATE VIOLATION AND IS AN UNFAIR TRADE PRACTICE. AN INSURER IS RESPONSIBLE TO ENSURE THAT ANY PERSON THAT PROCESSES HEALTH CARE CLAIMS ON ITS BEHALF COMPLIES WITH THIS SECTION.

(7) IF, AFTER OPPORTUNITY FOR A HEARING HELD PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969 PA 306, MCL 24.201 TO 24.328, THE COMMISSIONER DETERMINES THAT AN INSURER HAS VIOLATED THIS SECTION, 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 VIOLATING THIS SECTION AND SHALL ORDER PAYMENT OF A MONETARY PENALTY OF $5,000.00 FOR EACH VIOLATION. IF AN INSURER KNOWINGLY AND REPEATEDLY VIOLATES THIS SECTION, THE COMMISSIONER MAY ORDER THE SUSPENSION OR REVOCATION OF THE INSURER'S CERTIFICATE OF AUTHORITY OR LICENSE.

(8) AN INSURER THAT VIOLATES THIS SECTION SHALL PAY THE CLAIMANT INTEREST ON THE CLAIM PAYMENT AMOUNT COMPUTED AT THE RATE OF 18% PER ANNUM FROM THE DATE ON WHICH THE CLAIM PAYMENT AMOUNT WAS REQUIRED TO BE PAID UNTIL THE DATE ON WHICH THE CLAIM PAYMENT AMOUNT IS PAID IN FULL. INTEREST SHALL BE PAID AT THE TIME THE CLAIM PAYMENT AMOUNT IS PAID IN FULL.

(9) A POLICYHOLDER, COVERED PERSON, OR CLAIMANT MAY BRING A CIVIL ACTION AGAINST AN INSURER TO RECOVER THE CLAIM PAYMENT AMOUNT AND INTEREST PAYABLE UNDER SUBSECTION (8), TOGETHER WITH

ACTUAL ATTORNEY FEES AND LITIGATION EXPENSES AND COSTS. THIS SUBSECTION DOES NOT ABROGATE OR IMPAIR ANY OTHER LEGAL OR EQUITABLE ACTION, CLAIM, OR REMEDY THAT A POLICYHOLDER, COVERED PERSON, OR CLAIMANT MAY HAVE AGAINST AN INSURER.

(10) IF AN INSURER CONTRACTS TO PROVIDE BENEFITS AND REINSURES ALL OR A PORTION OF THE RISK, THE INSURER IS LIABLE FOR INTEREST DUE TO A CLAIMANT UNDER THIS SECTION IF A REINSURER FAILS TO PAY BENEFITS ON A TIMELY BASIS.

(11) A HEALTH CARE PROVIDER WHOSE MEMBERSHIP ON ANY PROVIDER PANEL IS TERMINATED SHALL BE PROVIDED WITH A WRITTEN EXPLANATION OF ALL REASONS FOR THE TERMINATION. THE PERSON WHO MAINTAINS THE PANEL SHALL FURNISH THE EXPLANATION TO THE HEALTH CARE PROVIDER WHEN THE HEALTH CARE PROVIDER IS GIVEN NOTICE OF TERMINATION.

(12) A PERSON SHALL NOT TERMINATE THE PARTICIPATION OF A HEALTH CARE PROVIDER ON ANY PROVIDER PANEL, OR OTHERWISE DISCRIMINATE AGAINST A HEALTH CARE PROVIDER, BECAUSE THE HEALTH CARE PROVIDER CLAIMS THAT A PERSON HAS VIOLATED THIS SECTION. A HEALTH CARE PROVIDER WHO ALLEGES A VIOLATION OF THIS SUBSECTION MAY BRING A CIVIL ACTION FOR APPROPRIATE INJUNCTIVE RELIEF, DAMAGES, OR BOTH, TOGETHER WITH ACTUAL ATTORNEY FEES AND LITIGATION EXPENSES AND COSTS.

(13) EACH INSURER SHALL RECEIVE AND PROCESS THOSE CLAIMS THAT ARE TRANSMITTED ELECTRONICALLY.

(14) FOR PURPOSES OF THIS SECTION:

(A) "CLAIM PAYMENT AMOUNT" MEANS THE AMOUNT THAT AN INSURER IS LIABLE TO PAY ON A HEALTH CARE CLAIM.

(B) "CLAIMANT" MEANS A PERSON WHO SUBMITS A HEALTH CARE CLAIM TO AN INSURER, INCLUDING A POLICYHOLDER, COVERED PERSON, OR HEALTH CARE PROVIDER.

(C) "CLEAN CLAIM" MEANS A HEALTH CARE CLAIM THAT CAN BE PROCESSED IN ACCORDANCE WITH AN INSURER'S REASONABLE PROCEDURES WITHOUT THE OBTAINING OF ADDITIONAL INFORMATION FROM THE CLAIMANT OR ANY OTHER PERSON.

(D) "HEALTH CARE CLAIM" MEANS A REQUEST FOR THE PAYMENT OF ANY OF THE FOLLOWING BENEFITS:

(*i*) BENEFITS UNDER AN EXPENSE-INCURRED HOSPITAL, MEDICAL, OR SURGICAL 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.

(*ii*) HOSPITAL, MEDICAL, SURGICAL, VISION, DENTAL, AND SICK CARE BENEFITS PROVIDED BY A MEWA REGULATED UNDER CHAPTER 70.

(*iii*) BENEFITS PROVIDED UNDER A HEALTH MAINTENANCE ORGANIZATION CONTRACT.

(*iv*) BENEFITS PROVIDED UNDER A HEALTH CARE CORPORATION CERTIFICATE.

(*v*) BENEFITS PROVIDED UNDER A QUALIFIED HEALTH PLAN.

(E) "HEALTH CARE PROVIDER" MEANS A PERSON LICENSED, CERTIFIED, OR REGISTERED UNDER PART 62 OR PARTS 161 TO 183 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.6201 TO 333.6251 AND 333.16101 TO 333.18311, OR A HEALTH FACILITY.

(F) "HEALTH FACILITY" MEANS:

(*i*) A FACILITY OR AGENCY LICENSED OR AUTHORIZED UNDER ARTICLE 17 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.20101 TO 333.22260.

(*ii*) A MENTAL HOSPITAL, PSYCHIATRIC HOSPITAL, PSYCHIATRIC UNIT, OR MENTAL RETARDATION FACILITY OPERATED BY THE DEPARTMENT OF MENTAL HEALTH OR CERTIFIED OR LICENSED UNDER THE MENTAL HEALTH CODE, 1974 PA 258, MCL 330.1001 TO 330.2106.

(*iii*) A FACILITY PROVIDING OUTPATIENT PHYSICAL THERAPY SERVICES, INCLUDING SPEECH PATHOLOGY SERVICES.

(*iv*) A KIDNEY DISEASE TREATMENT CENTER, INCLUDING A FREE-STANDING HEMODIALYSIS UNIT.

(*v*) AN ORGANIZED AMBULATORY HEALTH CARE FACILITY.

(*vi*) A TERTIARY HEALTH CARE SERVICE FACILITY.

(*vii*) A SUBSTANCE ABUSE TREATMENT PROGRAM LICENSED UNDER PARTS 61 TO 65 OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.6101 TO 333.6523.

(*viii*) AN OUTPATIENT PSYCHIATRIC CLINIC.

(*ix*) A HOME HEALTH AGENCY.

(G) "INSURER" INCLUDES A HEALTH MAINTENANCE ORGANIZATION, A QUALIFIED HEALTH PLAN, A HEALTH CARE CORPORATION, AND A MEWA REGULATED UNDER CHAPTER 70.

(H) "QUALIFIED HEALTH PLAN" MEANS, AT A MINIMUM, AN ORGANIZATION THAT MEETS THE CRITERIA FOR DELIVERING THE COMPREHENSIVE PACKAGE OF SERVICES UNDER THE DEPARTMENT OF COMMUNITY HEALTH'S COMPREHENSIVE HEALTH PLAN.

Enacting section 1. This amendatory act takes effect 6 months after it is enacted into law.