HOUSE BILL No. 5382

December 11, 2003, Introduced by Reps. Robertson, Taub, Vander Veen, Stahl, Voorhees, Ehardt, Sheen, Shackleton, Garfield, Woronchak, Ruth Johnson, Gaffney, Hoogendyk, Hune, Amos, Pastor, Condino and Kooiman and referred to the Committee on Insurance.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending section 2006 (MCL 500.2006), as amended by 2002 PA 316, and by adding section 2006a.

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

HOUSE BILL No. 5382

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 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 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 considered paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts 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 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) 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. 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, the insurer has refused payment in bad faith and the bad faith 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 is not 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) If a person contracts to provide benefits and reinsures all or a portion of the risk, the person contracting to provide

benefits 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) If there is any specific inconsistency between this section and 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 do not apply. Subsections (7) to (14) 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. Subsections (7) to (14) do not apply to the processing and paying of medicaid claims that are covered under section 111i of the social welfare act, 1939 PA 280, MCL 400.111i.

(7) Subsections (1) to (6) do not apply and subsections (8) to (14) do apply to health plans when paying claims to health professionals and health facilities that are not pharmacies and 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) Each health professional and health facility in billing for services rendered and each health plan in processing and paying claims for services rendered shall use the following timely processing and payment procedures:

(a) A clean claim shall 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.

(b) A health plan shall notify the health professional or health facility within 30 days after receipt of the claim by the health plan of all known reasons that prevent the claim from being a clean claim.

(c) A health professional and a health facility have 45 days, and any additional time the health plan permits, after receipt of a notice under subdivision (b) to correct all known defects. The 45-day time period in subdivision (a) is tolled from the date of receipt of a notice to a health professional or health facility under subdivision (b) to the date of the health plan's receipt of a response from the health professional or health facility.

(d) If a health professional's or health facility's response under subdivision (c) makes the claim a clean claim, the health plan shall pay the health professional or health facility within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(e) If a health professional's or health facility's response under subdivision (c) does not make the claim a clean claim, the health plan shall notify the health professional or health facility of an adverse claim determination and of the reasons for the adverse claim determination within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(f) A health professional or health facility shall bill a health plan within 1 year after the date of service or the date of discharge from the health facility in order for a claim to be

a clean claim.

(g) A health professional or health facility shall not resubmit the same claim to the health plan unless the time frame in subdivision (a) has passed or as provided in subdivision (c).

(9) Notices required under subsection (8) shall be made in writing or electronically. **Health plan, health professional, or health facility computer failure or malfunction does not toll any time periods under subsection (8).**

(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) A health plan shall not terminate the affiliation status or the participation of a health professional or health facility with a health maintenance organization provider panel or otherwise discriminate against a health professional or health facility because the health professional or health facility claims that a health plan has violated subsections (7) to (10).

(12) A health professional, health facility, or health plan alleging that a timely processing or payment procedure under subsections (7) to (11) has been violated may file a complaint with the commissioner on a form approved by the commissioner and has a right to a determination of the matter by the commissioner or his or her designee. This subsection does not prohibit a

health professional, health facility, or health plan from seeking court action. ~~A health plan described in subsection (14)(c)(*iv*) is subject only to the procedures and penalties provided for in subsection (13) and section 402 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1402, for a violation of a timely processing or payment procedure under subsections (7) to (11).~~

(13) In addition to any other penalty provided for by law, the commissioner may impose a civil fine of not more than $1,000.00 for each violation of subsections (7) to (11) not to exceed $10,000.00 in the aggregate for multiple violations.

(14) As used in subsections (7) to (13) **and section 2006a**:

(a) "Clean claim" means a claim that does all of the following:

(*i*) Identifies the health professional or health facility that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.

(*ii*) Sufficiently identifies the patient and health plan subscriber.

(*iii*) Lists the date and place of service.

(*iv*) Is a claim for covered services for an eligible individual.

(*v*) If necessary, substantiates the medical necessity and appropriateness of the service provided.

(*vi*) If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.

(*vii*) Identifies the service rendered using a generally accepted system of procedure or service coding.

(*viii*) Includes additional documentation based upon services rendered as reasonably required by the health plan.

(b) "Health facility" means a health facility or agency licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.

(c) "Health plan" means all of the following:

(*i*) 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, or 1-time limited duration policy or certificate, but not to payments made to an administrative services only or cost-plus arrangement.

(*ii*) A MEWA regulated under chapter 70 that provides hospital, medical, surgical, vision, dental, and sick care benefits.

(*iii*) A health maintenance organization licensed or issued a certificate of authority in this state.

(*iv*) A health care corporation for benefits provided under a certificate issued under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704, but not to payments made pursuant to an administrative services only or cost-plus arrangement.

(d) "Health professional" means a health professional licensed or registered under article 15 of the public health

code, 1978 PA 368, MCL 333.16101 to 333.18838.

Sec. 2006a. (1) A health plan, after consulting with health professionals and representatives of health facilities, shall establish clear and unambiguous policies and procedures for the submission of claims.

(2) A health plan shall not change or eliminate any coding, policy or procedure for the submission of claims, or reimbursement rate or methodology unless all of the following have been met:

(a) Written notice of the change or elimination, including the effective date of the change or elimination, has been sent to all affected health professionals and health facilities.

(b) The notice in subdivision (a) is sent not less than 45 days before the effective date of the change or elimination.

(c) The change or elimination takes effect on the date stated in the notice under subdivision (a) unless another notice is sent prior to the effective date that rescinds the change or elimination or extends the effective date of the change or elimination.

(3) A health professional or health facility alleging a violation of subsection (1) or (2) may file a complaint with the commissioner on a form approved by the commissioner and has a right to a determination of the matter by the commissioner or his or her designee. This subsection does not prohibit a health professional or health facility from seeking court action.

(4) In addition to any other penalty provided for by law, the commissioner may do the following for each violation of

subsection (1) or (2):

(a) Order payment to be made, along with simple interest at a rate of 12% per annum.

(b) Impose a civil fine or not more than $5,000.00 for each violation.

Enacting section 1. This amendatory act takes effect October 1, 2004.