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SFA BILL ANALYSIS

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Senate Bills 693 through 698 (as introduced 9-21-99)
Sponsor: Senator Bill Schuette
Committee: Health Policy

Date Completed: 2-29-00

CONTENT

Senate Bill 694 would amend the Insurance Code to require an "insurer" to pay a health care claim for benefits within 30 days (for a claim received by electronic transmission) or 45 days (for a claim received in hard copy); require payment of 18% interest on proper claims not paid on time; allow the Insurance Commissioner to order a $5,000 penalty for a violation of the bill; and specify grounds upon which an insurer could dispute its obligation to pay a claim. (An "insurer" would include a health maintenance organization (HMO); health care corporation; third party administrator; and multiple employer welfare arrangement (MEWA).

Senate Bill 693 would create the "Timely Payment of Health Care Claims Act", which would require payment of health care claims under provisions similar to those specified in Senate Bill 694, for "health care payors" other than insurers under Senate Bill 694. ("Health care payor" would mean a person who paid any part of the cost of a health care claim provided to a covered person, including an employer, a group of employers, any plan established by an employer or employer group, or any person who maintained or operated a network or panel of health care providers. The term would not include a health care provider, group medical practice, physician organization, physician/hospital organization, or other similar entity; or an individual who paid for any part of the cost of hospital, medical, surgical, vision, dental, or sick care benefits or services provided to the individual or his or her family member.)

Senate Bill 695 would amend the Worker's Disability Compensation Act to specify that the provisions of Senate Bill 694 would apply to certain health care benefits provided under the Act. Senate Bill 696 would amend the Nonprofit Health Care Corporation Reform Act, which governs Blue Cross and Blue Shield of Michigan (BCBSM), to provide that the provisions of Senate Bill 694 would apply to BCBSM. Senate Bill 697 would amend the Third Party Administrator Act to provide that the provisions of Senate Bill 694 would apply to a third party administrator. Senate Bill 698 would amend the Public Health Code to provide that the provisions of Senate Bill 694 would apply to HMOs.

Senate Bills 696 through 698 are tie-barred to Senate Bill 694. All of the bills contain an effective date of January 1, 2000, and would apply to all health claims submitted for payment after December 31, 1999.

Senate Bill 694

Timely Payment Requirement

Currently, Section 2006 of the Insurance Code requires insurers to pay benefits under a contract of insurance, on a timely basis. (This applies not just to health insurance, but to insurance in general.) An insurer must specify in writing the materials that constitute a satisfactory proof of loss within 30 days after receiving a claim. A claim is considered to be paid on a timely basis if paid within 60 days after the insurer receives proof of loss. The time period is extended if there is no recipient who can legally give a valid release for the payment, or if the insurer is unable to determine who is entitled to receive payment. The insured is entitled to interest at 12% per year for claims not paid on a timely basis. Failure to pay claims on a timely basis, or to pay interest as required, is an unfair trade practice unless a claim is reasonably in dispute.

The bill provides that Section 2006 would not apply to any of the following:

-- Hospital, medical, surgical, vision, dental, and sick care benefits provided by a MEWA, or under a policy or certificate of worker's compensation insurance.
-- Benefits provided under an expense-incurred hospital, medical, surgical, vision, or dental

policy or certificate, including any policy or certificate providing coverage for specific diseases or accidents only, or any hospital indemnity, Medicare supplement, long-term care, disability income, or one-time limited duration policy or certificate.

-- Hospital, medical, surgical, vision, dental, and sick care benefits provided under a policy or certificate regulated under Chapter 31 of the Code, which governs motor vehicle personal and property protection insurance.

The bill would require an insurer to pay in full the claim payment amount (the amount an insurer was liable to pay on a health care claim) for a "health care claim", or any disputed part of a health care claim, within 30 days following receipt of a "clean claim" by electronic transmission, or within 45 days following receipt of a clean claim by hard copy. "Health care claim" would mean a request for the payment of any of the following benefits:

-- Benefits under an expense-incurred hospital, medical, surgical, vision, or dental policy or certificate, including any policy or certificate that provided coverage for specific diseases or accidents only, or any hospital indemnity, Medicare supplement, long-term care, disability income, or one-time limited duration policy or certificate.
-- Hospital, medical, surgical, vision, dental, and sick care benefits provided under a policy or certificate regulated under Chapter 31 of the Code.
-- Hospital, medical, surgical, vision, dental, and sick care benefits provided by a MEWA; or under a policy or certificate of worker's compensation insurance.
-- Benefits provided under an HMO contract.
-- Benefits provided under a health care corporation certificate.
-- Claims for benefits administered by a third party administrator.

A "clean claim" would be a health care claim that could be processed in accordance with an insurer's reasonable procedures, without the obtaining of additional information from the claimant or any other person.

Claim Determination/Disputes/Interest

The bill provides that a health care claim would be considered a clean claim unless an insurer, within 30 days after receiving a claim by electronic transmission or within 45 days after receiving a claim by hard copy, requested 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 claim would be considered a clean claim. An insurer that requested additional information that was not reasonably needed to determine liability to pay a claim would be liable for the payment of interest.

An insurer would have to pay a clean claim within the applicable 30- and 45-day time periods unless the insurer reasonably disputed its obligation to pay the clean claim, in whole or in part, based on one or more of the following grounds:

-- The eligibility of a person for coverage.
-- The liability of another insurer or person for all or part of the claim.
-- The amount of the claim.
-- The covered benefits.
-- The manner in which services were "accessed" or provided.
-- That the claim was submitted fraudulently, so long as there was a reasonable basis supported by specific information available for review by the Insurance Commissioner to support this belief.

An insurer that violated these provisions, or unreasonably disputed liability to pay a claim, would be liable for the payment of interest. Following receipt of a clean claim and within the applicable 30- and 45-day time periods, an insurer that disputed its obligation to pay a clean claim, in whole or in part, would have to notify the claimant in writing that it was not obligated to pay some or all of the claim, and state with specificity all reasons why it was not liable.

Violations/Civil Action

An insurer that violated the bill would have to pay a claimant interest on the claim payment amount, computed at 18% per year from the date on which the claim was required to be paid until the date the claim was paid in full. Interest would have to be paid at the time the claim payment was paid in full. If an insurer contracted to provide benefits and reinsured all or a portion of the risk, the insurer would be liable for interest due to a claimant if a reinsurer failed to pay benefits on a timely basis.

If, after opportunity for a hearing held pursuant to the Administrative Procedures Act, the Commissioner determined that an insurer had violated the bill, the Commissioner would have to issue and cause to be served upon the insurer a written copy of the findings and an order requiring the insurer to cease and desist from the violation. The Commissioner also would have to order payment of a $5,000 penalty for each violation. If an insurer knowingly and repeatedly violated the bill, the Commissioner could order the suspension or revocation of the insurer's certificate of authority or license.

Each health care claim processed in violation of the bill would constitute a separate violation and would be an unfair trade practice. An insurer would be responsible to ensure that any person that processed health care claims on its behalf complied with the bill.

The bill would allow a policyholder, covered person, or claimant to bring a civil action against an insurer to recover the claim payment amount and applicable interest, together with actual attorney fees and litigation expenses and costs. This provision would not abrogate or impair any other legal or equitable action, claim, or remedy that a policyholder, covered person, or claimant could have against an insurer.

Provider Panel

A person could not terminate the participation of a health care provider on any provider panel, or otherwise discriminate against a provider, because the provider claimed that a person had violated the bill. A health care provider who alleged a violation could bring a civil action for appropriate injunctive relief, damages, or both, together with actual attorney fees and litigation expenses and costs.

A provider whose membership on any provider panel was terminated would have to be given a written explanation of all the reasons for the termination. The person who maintained the panel would have to furnish the explanation when the provider was given notice of termination.

Senate Bill 693

The bill would require the payment of health care claims in the same manner as required under Senate Bill 694, except that Senate Bill 693 would apply to health care payors instead of entities considered insurers under Senate Bill 694. Further, Senate Bill 693 would define "health care claim" as a request for the payment of hospital, medical, surgical, vision, dental, or sick care benefits or services.

Senate Bill 695

The bill provides that the provisions proposed in Senate Bill 694 would apply to hospital, medical, surgical, and sick care benefits provided under Section 315 of the Worker's Disability Compensation Act. (Section 315 requires an employer to furnish, or cause to be furnished, to an employee who receives a personal injury arising out of and in the course of employment, reasonable medical, surgical, hospital services and medicines, or other treatment.) Senate Bill 695 would apply to an employer that received authorization from the Director of the Bureau of Worker's Disability Compensation to be a self-insurer, or two or more employers permitted by the Director to enter into agreements to pool their liabilities under the Act for the purpose of qualifying as self-insurers.

Senate Bill 696

The bill provides that the provisions proposed in Senate Bill 694 would apply to BCBSM.

Currently, if BCBSM does not pay a claim within 60 days after receiving a claim form, interest on the claim accrues at a rate of 12% per year. The bill would delete this provision.

Senate Bill 697

The bill provides that the proposed provisions in Senate Bill 694 would apply to a third party administrator.

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Senate Bill 698

The bill provides that the proposed provisions in Senate Bill 694 would apply to an HMO.

Further, the bill provides that if an HMO paid a health care provider, in whole or in part, on the basis of "capitation", all of the following would apply:

-- Capitation payments would have to begin within 30 days after an enrollee was first "assigned" to a health care provider. Thereafter, capitation payments would have to be made at least once every 30 days while an enrollee remained assigned to a health care provider.
-- An HMO would have to furnish each health care provider paid on a capitation basis with written notice of each enrollee assigned to the health care provider. The written notice would have to be furnished at least once every 30 days.

If an HMO violated these requirements, provisions of Senate Bill 694 concerning a hearing, penalties, and civil liability would apply.

"Capitation" would mean a fixed amount per assigned enrollee payable to a health care provider on a periodic basis for providing, or arranging for others to provide, some or all of the services covered under an HMO contract covering the enrollee. "Assigned" would mean the assignment of an enrollee to a health care provider by an HMO or the selection of a health care provider by an enrollee, by which the provider was responsible to provide, or to arrange for the provision of, some or all of the services covered under an HMO contract covering the enrollee.

MCL 500.2006 et al. (S.B. 694)
Proposed MCL 418.315a (S.B. 695)
MCL 550.1403 (S.B. 696)
Proposed MCL 550.921 (S.B. 697)
Proposed MCL 333.21095 & 333.21095a (S.B. 698)

Legislative Analyst: G. Towne

FISCAL IMPACT

According to the Insurance Bureau, the fiscal impact of these bills is indeterminate. The additional responsibilities that would be required of the Bureau could require an increase of staff and other administrative costs. The bills would allow fines to be collected from a health care payor but with no information about the number of violations, there is no way to determine if the revenue collected would be sufficient to cover the additional administrative costs.

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