Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

SFA BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 694 (Substitute S-4 as passed by the Senate)
Senate Bill 696 (Substitute S-1 as passed by the Senate)
Senate Bill 698 (Substitute S-1 as passed by the Senate)
Sponsor: Senator Bill Schuette
Committee: Health Policy

Date Completed: 9-8-00

RATIONALE

According to individual health professionals, groups, and organizations that represent various health professions and facilities, there is increasing difficulty in obtaining proper and timely reimbursement from health insurers and health plans for services rendered. In fact, some accuse insurers of employing tactics to reduce, delay, or completely avoid payment of claims. On the other hand, insurers point to the enormous volume of claims submitted, and contend that claims often are submitted improperly or for uncovered services. Whatever the reason, there is widespread agreement among health professionals that accounts receivable are increasing, and that this increase is placing great financial strain on individual providers and the entire health care system. Some people believe that the State should provide a regulatory structure to ensure the proper submission of claims by providers, the timely payment of claims by health insurers, a procedure for the resolution of disputes, and penalties for failure to comply with timely claim payment requirements.

CONTENT

Senate Bill 694 (S-4) would amend the Insurance Code to require a "health plan", a health professional, and a health facility to follow a specified timely claims processing and payment procedure, which the Commissioner of the Office of Financial and Insurance Services would have to establish; and prescribe the content of the procedure, including a requirement that a clean claim be paid within 45 days after it was received by a health plan, or bear interest at a 12% annual rate.

Senate Bill 696 (S-1) would amend the Nonprofit Health Care Corporation Reform Act, which regulates Blue Cross and Blue Shield of Michigan (BCBSM), to specify that the provisions of Senate Bill 694 (S-4) would apply to BCBSM; and to delete a provision that interest on a claim accrues at a rate of 12% per year, if BCBSM does not pay the claim within 60 days after receiving a claim form. Senate Bill 698 (S-1) would amend the Public Health Code to specify that the provisions of Senate Bill 694 (S-4) would apply to health maintenance organizations (HMOs).

The bills would take effect January 1, 2001, and apply to all health care claims submitted for payment after December 31, 2000. Senate Bills 696 (S-1) and 698 (S-1) are tie-barred to Senate Bill 694.

A more detailed description of Senate Bill 694 (S-4) follows.

The bill would define "health plan" as any of the following: an insurer providing 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 multiple employer welfare arrangement (MEWA) regulated under the Insurance Code; an HMO; or a health care corporation operating under the Nonprofit Health Care Corporation Reform Act. The bill would not apply to an entity regulated under the Worker's Disability Compensation Act, or to claims arising out of that Act or those provisions of the Insurance Code that regulate motor vehicle personal and property protection.

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 states that these provisions would not apply to health plans.

The bill would require the Commissioner to establish a timely claims processing and payment procedure to be used by health professionals and facilities in billing for, and by health plans in processing and paying claims for, services rendered. The Commissioner would have to consult with the Department of Community Health, health professionals and facilities, and health plans in establishing the timely payment procedure. The procedure established by the Commissioner would have to provide that a "clean claim" would mean a claim that, at a minimum, was for covered services and did the following:

-- Identified the health professional or health facility that provided treatment or service, including a matching identifying number.
-- Identified the patient and health plan subscriber.
-- Listed the date and place of service.
-- If necessary, substantiated the medical necessity and appropriateness of the care or service provided.
-- If prior authorization were required for certain patient care or services, included the authorization number.
-- Included additional documentation based upon services rendered as reasonably required by the health plan.

Further, the timely claims payment procedure would have to provide for all of the following:

-- A universal system of coding to be used for all claims submitted to health plans. If the Federal government developed a universal coding system, it would be used in place of the coding developed under the bill.
-- That a claim would have to be transmitted electronically or as otherwise specified by the Commissioner, and that a health plan would have to be able to receive a claim transmitted in that manner.
-- The number of days after a service was provided within which a health professional and facility would have to bill a health plan for the claim.
-- That a clean claim would have to be paid within 45 days after the health plan received it. A clean claim that was not paid within 45 days would have to bear simple interest at a rate of 12% per year.
-- That a health plan would have to state in writing to the health professional or facility any defect in the claim within 30 days after receiving it.
-- That a health professional and a health facility would have 30 days, after receiving a notice that a claim or a portion of a claim was defective, within which to correct the defect. The health plan would have to pay the claim within 30 days after the defect was corrected.
-- That a health plan would have to notify the health professional or facility of the defect if a claim or a portion of a claim were returned from a health professional or facility and remained defective for the original reason or a new reason.
-- That a health plan would have to report to the Commissioner the number of claims that had not been paid within the time limits prescribed by the bill. The report would be due on January 1, April 1, July 1, and October 1 each year. (A report would not be due for the six months following the bill's effective date.)
-- Penalties to be applied to health professionals, health facilities, and health plans for failing to adhere to the timely claims payment procedure.
-- A system for notifying the licensing entity if a penalty were incurred.
-- That if a health plan, professional, or facility disagreed with the penalty imposed by the Commissioner or his or her designee, the Commissioner or designee would have to hear the matter as a contested case under the Administrative Procedures Act.

If a health plan determined that one or more services listed on a claim were payable, the health plan would have to pay for those services, and could not deny the entire claim because one or more other services listed on it were defective. This provision would not apply if a health plan and a health professional or facility had an overriding contractual reimbursement arrangement.

The bill would require the Commissioner to report to the Senate and House of Representatives standing committees on health issues and insurance issues by October 1, 2001, on the timely claims processing and payment procedure established under the bill.

MCL 500.2006 et al. (S.B. 694)
550.1403 (S.B. 696)
Proposed MCL 333.21095 (S.B. 698)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Health care providers and health care facilities across the State have reported that delayed or denied payments from health plans for services rendered have become a chronic problem in the

health care system, and have caused an unnecessary strain on the entire health care delivery system. Doctors, in individual practices or in small or large group practices, have difficulty covering overhead (salaries, benefits, taxes, utilities, supplies, rent for office space, etc.) when insurers routinely withhold payments and accounts receivable rise. Health care providers, through their services, time, and expenditures, pay each day for the costs of health care in the State and then must wait months for reimbursement, while third-party payers hold on to premiums and earn interest on the money. This imposes a great financial stress on providers and facilities, and places an unfair burden on health care workers. By specifying procedures and deadlines for payments, and providing penalties for noncompliance, the bills would help to reduce problems in the health care system.

Response: The bills would have no effect on certain health plans that cover a significant number of persons. Under a Federal law, the Employee Retirement Income Security Act (ERISA, which regulates employee benefit and pension plans), states are preempted from regulating self-funded employer health plans.

Supporting Argument

As a rising percentage of a provider's or facility's assets is tied up in accounts receivable, more of the resources of the practice must be devoted to billing, claim forms, and collections. Eventually, the providers themselves must devote more time and attention to business administration issues, and thus have less time for patient care. The increased time and effort of a practice's providers and employees not only adversely affect patient care, but also increase the costs of patient care without providing any increased benefits to the patient.

Supporting Argument

The Insurance Code requires insurers to pay benefits on a timely basis under a contract of insurance, including insurance for health care benefits. In addition to prescribing deadlines for the payment of claims, the Code provides that an insured is entitled to 12% interest for claims not paid on time. The Nonprofit Health Care Corporation Reform Act has a similar provision for BCBSM. Despite these requirements, there is little chance that a health care provider can pressure an insurer to pay in a timely manner, since the provisions do not allow a provider to initiate a complaint or action against the insurer for payment. This leaves the insurer with no penalty for routinely making late payments, and the health care providers without the ability to enforce payment. Under the bills, penalties would be imposed on health plans that failed to adhere to the specified payment schedule. Currently, insurers apply late fee penalties if premiums are not paid on time, and will cancel benefits if premiums are not paid by a certain date, but they suffer no penalty for withholding payments for legitimate claims. The bills would correct this inequity.

Response: While the Insurance Code currently does not provide a direct penalty for an insurer that refuses to pay a provider for a legitimate claim, providers may sue an insurer for breach of contract if an insurer refuses to pay a claim, or shows a pattern of refusing to pay claims. This is the same remedy that can be used by any party to a contract if one or more parties fail to fulfill contractual obligations.

Opposing Argument

The bills would place the State in the position of regulating, in detail, the business relationship among health care providers and insurers. This would not necessarily be the best use of the State's resources, or the optimal method to resolve administrative problems in the health care insurance system. Rather than having a State regulator intervene in their business relationship, the providers and insurers who enter into contracts for health care services should be encouraged to negotiate the terms of their agreements with attention to the kinds of detail Senate Bill 694 (S-4) includes pertaining to clean claims, electronic transmission, universal coding, and payment schedules. These agreements also should include consequences and repercussions that could address failures to live up to contractual responsibilities, and the parties should avail themselves of these remedies. If an insurer failed to comply with a contractual agreement, health care providers would be free to choose not to renew the contract and the insurer would lose valuable business. This would be the most effective way to encourage prompt payment of claims, rather than placing the State in the claims payment process.

Opposing Argument

Some proponents of the bills have claimed that insurers needlessly and intentionally delay payments to providers, so that insurers can keep premiums for as long as possible for investment purposes. It is highly unlikely that an entire industry of competing insurers has told its employees to delay payments, or lose files, and then keep quiet. It is much more likely that delayed payments are the result of errors, made by both providers and insurers. It must be remembered that insurers process thousands of claims per month. Given this volume, even if providers submit a small percentage of the total with errors, or insurers legitimately question a fraction of the total submitted, the actual number of claims payments delayed will be significant. It is understandable that delays are bothersome to

A9900\s694a

providers who are waiting for their payments, but it also is understandable that providers and insurers both will make errors in processing the vast number of complicated claims that are submitted. The solution to the problem of delayed payments is to reduce the incidence of errors. The bills would have little effect in reducing the error rate. Of greater significance would be the development of standardized electronic claims administration systems. According to insurance representatives, such systems are in development and nearing deployment.

Response: While it is inevitable that some errors will occur in the processing of claims, what disturbs providers the most is insurers' apparent rejection of and refusal to pay for clean claims. Under the current system, providers have no statutory authority to require insurers to pay legitimate claims on a timely basis. Reportedly, 37 states now have some form of "clean claim" laws and specified payment schedule requirements, and Michigan should offer its health care providers the same protections. The bills would provide a remedy for providers who suffer when payments are not made for services rendered.

Legislative Analyst: G. Towne

FISCAL IMPACT

According to the Office of Financial and Insurance Services, the fiscal impact of Senate Bills 694 (S-4), 696 (S-1), and 698 (S-1) is indeterminate. The additional responsibilities that would be required of the Office could require an increase of staff and other administrative costs.

Fiscal Analyst: M. Tyszkiewicz