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SFA BILL ANALYSIS

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Senate Bill 694 (Substitute S-1)
Senate Bill 696 (Substitute S-1)
Senate Bill 698 (Substitute S-1)
Sponsor: Senator Bill Schuette
Committee: Health Policy

Date Completed: 3-3-00

CONTENT

Senate Bill 694 (S-1) would amend the Insurance Code to require a "health plan" to follow specified timely claims payment procedures, which the Insurance Commissioner would have to establish; and prescribe the content of the procedures, including a provision that a clean claim would have to be paid within 45 days after it was received by a health plan, or bear interest at an 18% annual rate. A "health plan" would be 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 Code; a health maintenance organization (HMO); a third party administrator (TPA) licensed under the Third Party Administrator Act; or a health care corporation operating under the Nonprofit Health Care Corporation Reform Act, which regulates Blue Cross and Blue Shield of Michigan (BCBSM).

Senate Bill 696 (S-1) would amend the Nonprofit Health Care Corporation Reform Act to provide that the provisions of Senate Bill 694 (S-1) 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 provide that the provisions of Senate Bill 694 (S-1) would apply to 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-1) follows.

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 payment procedure to be used by health professionals and facilities in billing for, and health plans in 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 timely payment procedures. The procedures 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 date, time, type of care or services authorized, and the name of the person authorizing that care or service.
-- Included additional documentation based upon services rendered as reasonably required by the health plan.

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

-- A universal system of coding to be used for all claims submitted to health plans.
-- 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 electronically.
-- 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 the claim. A clean claim that was not paid within 45 days would have to bear simple interest at a rate of 18% 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 the claim
-- 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 15 days after the defect was corrected.
-- That a health plan would have to notify the health professional or facility and the Commissioner 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.
-- 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.

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 the claim were defective.

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, and each year thereafter, on the timely claims payment procedures established under the bill.

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

Fiscal Analyst: M. Tyszkiewicz

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