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SFA BILL ANALYSIS

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Senate Bill 938 (as introduced 1-25-00)
Sponsor: Senator Joel D. Gougeon
Committee: Families, Mental Health and Human Services

Date Completed: 2-1-00

CONTENT

The bill would amend the Social Welfare Act to require the Insurance Commissioner to establish a reasonable timely claims payment procedure to be used by health professionals and facilities in billing for, and by qualified health plans in paying claims for, Medicaid services rendered. The bill identifies what the timely claims payment procedure would have to provide for, including a requirement that a "clean claim" be paid within 60 days, notification and correction of defects in a claim, a dispute resolution process, and penalties for chronic conduct resulting in unreasonable delays. In establishing the timely payment procedure, the Commissioner would have to consult with the Department of Community Health (DCH), health professionals and facilities, and qualified health plans. ("Qualified health plan" would mean, at a minimum, an organization that met the criteria for delivering the comprehensive package of services under the DCH's comprehensive health plan.)

The timely claims payment procedure established by the Insurance Commissioner would have to provide that "clean claim" would mean a claim that, at a minimum:

-- Included necessary health professional, health facility, and patient data.
-- Was for covered services.
-- Was certified for accuracy and had the proper information identifying the health care provider, as required under the Act.
-- If necessary, substantiated the medical necessity and appropriateness of the care or service provided.
-- If 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.

The timely claims payment procedure also would have to provide for all of the following:

-- A universal system of coding to be used for all Medicaid claims submitted to qualified health plans.
-- That a claim would have to be transmitted electronically or as otherwise specified by the Commissioner.
-- The number of days after a service was provided within which a health professional and facility would have to bill a qualified health plan for the claim.
-- That a clean claim would have to be paid within 60 days.
-- That a qualified health plan would have to state in writing 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 was defective within which to correct the defect.
-- The number of days within which the qualified health plan would have to notify the health professional or facility and the Commissioner of the defect, if a claim were returned from a health professional or facility within the allowable 30-day period and the claim remained defective for the original reason or a new reason.
-- A dispute resolution process to be arbitrated by the Commissioner or his or her designee to resolve claim disputes after the Commissioner received notice of a claim defect after the 30-day period.
-- Penalties to be applied to health professionals, health facilities, and qualified health plans for chronic

patterns of conduct that resulted in unreasonable delays in paying claims.

-- A system for notifying the licensing entity if a penalty were incurred for chronic patterns of conduct that resulted in unreasonable delays in paying claims.

By October 1, 2000, the DCH would be prohibited from entering into or renewing a contract with a qualified health plan unless the qualified health plan agreed to follow the timely claims payment procedure established under the bill and required health professionals and facilities under contract with the plan to follow the timely claims payment procedure.

By April 1, 2001, and then annually, the Insurance Commissioner and the DCH would have to report to the Senate and House Appropriations subcommittees on community health as to whether there existed a pattern of abuse of the timely claims payment procedure established under the bill. The Commissioner and the DCH also would have to survey and report whether a timely claims payment procedure was needed for the payment of health care claims other than Medicaid claims.

MCL 400.111a et al.

Legislative Analyst: P. Affholter

FISCAL IMPACT

The bill would codify a claims resolution process similar to that contained in boilerplate language in Public Act 114 of 1999, the FY 1999-2000 Department of Community Health budget. As the bill does not have any language specifying the level of any penalties, an accurate fiscal impact cannot be determined.

The bill would require the Department of Consumer and Industry Services to set up a dispute resolution process and perform additional claims administration responsibilities, as well as compile and present a report to the Legislature. These functions would require the hiring of additional staff. The costs would probably be covered from fee revenues already collected by the Insurance Bureau for other insurance regulatory purposes and penalty revenue that could be collected pursuant to this bill.

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