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 1426 (Substitute S-1 as reported)
Sponsor: Senator Bill Schuette
Committee: Health Policy

Date Completed: 11-21-00

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. 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. 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.

Toward that end, the Senate and the House passed Senate Bill 694, although in different versions. The latest version, as passed by the House, 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. A pharmaceutical clean claim would have to be paid within 45 days or within the industry standard time frame for paying a claim, whichever was sooner.

Currently, the bill is before a conference committee. A companion bill, Senate Bill 696, would have amended the Nonprofit Health Care Corporation Reform Act to apply the provisions of Senate Bill 694 to Blue Cross and Blue Shield of Michigan (BCBSM). The bill was passed by both houses of the Legislature and sent to the Governor. The Governor vetoed the bill, stating that because the provisions of Senate Bill 696 depended on the language in Senate Bill 694, and because that bill was still pending before the Legislature, he would not approve Senate Bill 696. It has been suggested that other legislation should apply the provisions of Senate Bill 694 to BCBSM, in the event that bill is enacted.

CONTENT

The bill would amend the Nonprofit Health Care Corporation Reform Act to specify that a proposed section of the Insurance Code, concerning a timely claims payment procedure, would apply to BCBSM. The proposed section is contained in Senate Bill 694, to which this bill is tie-barred.

Currently, under the Act, BCBSM must specify in writing the materials that constitute a satisfactory claim form within 30 days after receiving a claim. If a claim form is not supplied as to the entire claim, the amount supported by the claim form is considered to be paid on a timely basis if paid within 60 days after receipt of the form by BCBSM. Under the bill, these provisions would not apply to BCBSM when it paid a claim pursuant to Senate Bill 694.

Senate Bill 1426 would take effect January 1, 2001, and apply to all health care claims submitted for payment after December 31, 2000.

MCL 550.1403

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 industry, 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 that the payment procedures, deadlines, and penalties proposed by Senate Bill 694 would apply to BCBSM, Senate Bill 1426 (S-1) would help to reduce problems in the health care system.

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 bill, penalties would be imposed on BCBSM if it failed to adhere to the specified payment schedule.

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, including a contract with BCBSM, if one or more parties fail to fulfill contractual obligations.

Opposing Argument

Senate Bills 694 and 1426 (S-1) would place the State in the position of regulating, in detail, the business relationship among health care providers and BCBSM. 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 parties 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 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 or BCBSM failed to comply with a contractual agreement, health care providers would be free to choose not to renew the contract and the insurer or BCBSM 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.

Legislative Analyst: G. Towne

FISCAL IMPACT

According to the Office of Financial and Insurance Services, the fiscal impact of this bill and Senate Bill 694 (H-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

A9900\s1426a