

**HOUSE SUBSTITUTE FOR
SENATE BILL NO. 694**

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending section 2006 (MCL 500.2006).

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 2006. (1) A person must pay on a timely basis to its
2 insured, an individual or entity directly entitled to benefits
3 under its insured's contract of insurance, or a third party tort
4 claimant the benefits provided under the terms of its policy, or,
5 in the alternative, the person must pay to its insured, an indi-
6 vidual or entity directly entitled to benefits under its
7 insured's contract of insurance, or a third party tort claimant
8 12% interest, as provided in subsection (4), on claims not paid
9 on a timely basis. Failure to pay claims on a timely basis or to
10 pay interest on claims as provided in subsection (4) is an unfair
11 trade practice unless the claim is reasonably in dispute.

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1 (2) A person shall not be found to have committed an unfair
2 trade practice under this section if the person is found liable
3 for a claim pursuant to a judgment rendered by a court of law,
4 and the person pays to its insured, individual or entity directly
5 entitled to benefits under its insured's contract of insurance,
6 or third party tort claimant interest as provided in subsection
7 (4).

8 (3) An insurer shall specify in writing the materials
9 ~~which~~ THAT constitute a satisfactory proof of loss not later
10 than 30 days after receipt of a claim unless the claim is settled
11 within the 30 days. If proof of loss is not supplied as to the
12 entire claim, the amount supported by proof of loss shall be
13 ~~deemed to be~~ CONSIDERED paid on a timely basis if paid within
14 60 days after receipt of proof of loss by the insurer. Any part
15 of the remainder of the claim that is later supported by proof of
16 loss shall be ~~deemed to be~~ CONSIDERED paid on a timely basis if
17 paid within 60 days after receipt of the proof of loss by the
18 insurer. ~~Where~~ IF the proof of loss provided by the claimant
19 contains facts ~~which~~ THAT clearly indicate the need for addi-
20 tional medical information by the insurer in order to determine
21 its liability under a policy of life insurance, the claim shall
22 be ~~deemed to be~~ CONSIDERED paid on a timely basis if paid
23 within 60 days after receipt of necessary medical information by
24 the insurer. Payment of a claim shall not be untimely during any
25 period in which the insurer is unable to pay the claim when there
26 is no recipient who is legally able to give a valid release for
27 the payment, or where the insurer is unable to determine who is

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1 entitled to receive the payment, if the insurer has promptly
2 notified the claimant of that inability and has offered in good
3 faith to promptly pay the claim upon determination of who is
4 entitled to receive the payment.

5 (4) ~~When~~ IF benefits are not paid on a timely basis the
6 benefits paid shall bear simple interest from a date 60 days
7 after satisfactory proof of loss was received by the insurer at
8 the rate of 12% per annum, if the claimant is the insured or an
9 individual or entity directly entitled to benefits under the
10 insured's contract of insurance. ~~Where~~ IF the claimant is a
11 third party tort claimant, then the benefits paid shall bear
12 interest from a date 60 days after satisfactory proof of loss was
13 received by the insurer at the rate of 12% per annum if the
14 liability of the insurer for the claim is not reasonably in
15 dispute, ~~and~~ the insurer has refused payment in bad faith ~~,~~
16 ~~such~~ AND THE bad faith ~~having been~~ WAS determined by a court
17 of law. The interest shall be paid in addition to and at the
18 time of payment of the loss. If the loss exceeds the limits of
19 insurance coverage available, interest shall be payable based
20 upon the limits of insurance coverage rather than the amount of
21 the loss. If payment is offered by the insurer but is rejected
22 by the claimant, and the claimant does not subsequently recover
23 an amount in excess of the amount offered, interest ~~shall~~ IS
24 not ~~be~~ due. Interest paid pursuant to this section shall be
25 offset by any award of interest that is payable by the insurer
26 pursuant to the award.

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1 (5) ~~Where~~ IF a person contracts to provide benefits and
2 reinsures all or a portion of the risk, the person contracting to
3 provide benefits ~~shall be~~ IS liable for interest due to an
4 insured, an individual or entity directly entitled to benefits
5 under its insured's contract of insurance, or a third party tort
6 claimant under this section where a reinsurer fails to pay bene-
7 fits on a timely basis.

8 (6) ~~In the event of~~ IF THERE IS any specific inconsistency
9 between this section and ~~the provisions of Act No. 294 of the~~
10 ~~Public Acts of 1972, as amended, being sections 500.3101 to~~
11 ~~500.3177 of the Compiled Laws of 1970 or of the provisions of Act~~
12 ~~No. 317 of the Public Acts of 1969, as amended, being sections~~
13 ~~418.101 to 418.941 of the Compiled Laws of 1970,~~ SECTIONS 3101
14 TO 3177 OR THE WORKER'S DISABILITY COMPENSATION ACT OF 1969, 1969
15 PA 317, MCL 418.101 TO 418.941, the provisions of this section
16 ~~shall~~ DO not apply. SUBSECTIONS (7) TO (12) DO NOT APPLY TO AN
17 ENTITY REGULATED UNDER THE WORKER'S DISABILITY COMPENSATION ACT
18 OF 1969, 1969 PA 317, MCL 418.101 TO 418.941.

19 (7) SUBSECTIONS (1) TO (6) DO NOT APPLY AND SUBSECTIONS (8)
20 TO (12) DO APPLY TO HEALTH PLANS WHEN PAYING CLAIMS TO HEALTH
21 PROFESSIONALS AND FACILITIES THAT DO NOT INVOLVE CLAIMS ARISING
22 OUT OF SECTIONS 3101 TO 3177 OR THE WORKER'S DISABILITY COMPENSA-
23 TION ACT OF 1969, 1969 PA 317, MCL 418.101 TO 418.941.

24 (8) THE COMMISSIONER SHALL ESTABLISH A TIMELY CLAIMS PRO-
25 CESSING AND PAYMENT PROCEDURE TO BE USED BY HEALTH PROFESSIONALS
26 AND FACILITIES IN BILLING FOR, AND HEALTH PLANS IN PROCESSING AND
27 PAYING CLAIMS FOR, SERVICES RENDERED. THE COMMISSIONER SHALL

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1 CONSULT WITH THE DEPARTMENT OF COMMUNITY HEALTH, HEALTH
2 PROFESSIONALS AND FACILITIES, AND HEALTH PLANS IN ESTABLISHING
3 THIS TIMELY PAYMENT PROCEDURE.

4 (9) THE TIMELY CLAIMS PROCESSING AND PAYMENT PROCEDURE
5 ESTABLISHED BY THE COMMISSIONER UNDER SUBSECTION (8) SHALL PRO-
6 VIDE FOR ALL OF THE FOLLOWING:

7 (A) THAT A "CLEAN CLAIM", FOR THE PURPOSES OF THIS SECTION,
8 MEANS A CLAIM THAT DOES AT A MINIMUM ALL OF THE FOLLOWING:

9 (i) IDENTIFIES THE HEALTH PROFESSIONAL OR HEALTH FACILITY
10 THAT PROVIDED TREATMENT OR SERVICE, INCLUDING A MATCHING IDENTI-
11 FYING NUMBER.

12 (ii) IDENTIFIES THE PATIENT AND HEALTH PLAN SUBSCRIBER.

13 (iii) LISTS THE DATE AND PLACE OF SERVICE.

14 (iv) IS FOR COVERED SERVICES FOR AN ELIGIBLE INDIVIDUAL.

15 (v) IF NECESSARY, SUBSTANTIATES THE MEDICAL NECESSITY AND
16 APPROPRIATENESS OF THE CARE OR SERVICE PROVIDED.

17 (vi) IF PRIOR AUTHORIZATION IS REQUIRED FOR CERTAIN PATIENT
18 CARE OR SERVICES, INCLUDES THE AUTHORIZATION NUMBER.

19 (vii) INCLUDES ADDITIONAL DOCUMENTATION BASED UPON SERVICES
20 RENDERED AS REASONABLY REQUIRED BY THE HEALTH PLAN.

21 (B) A UNIVERSAL SYSTEM OF CODING TO BE USED ON ALL CLAIMS
22 SUBMITTED TO HEALTH PLANS. IF A UNIVERSAL CODING SYSTEM IS
23 DEVELOPED BY THE FEDERAL GOVERNMENT, IT WILL BE USED IN PLACE OF
24 THE CODING DEVELOPED PURSUANT TO THIS SECTION.

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1 (C) THAT A CLAIM MUST BE TRANSMITTED ELECTRONICALLY OR AS
2 OTHERWISE SPECIFIED BY THE COMMISSIONER AND A HEALTH PLAN MUST BE
3 ABLE TO RECEIVE A CLAIM TRANSMITTED ELECTRONICALLY OR AS OTHER-
4 WISE SPECIFIED BY THE COMMISSIONER.

5 (D) THE NUMBER OF DAYS AFTER A SERVICE WAS PROVIDED WITHIN
6 WHICH A HEALTH PROFESSIONAL AND FACILITY MUST BILL A HEALTH PLAN
7 FOR THE CLAIM.

8 (E) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBDIVISION, THAT A
9 CLEAN CLAIM MUST BE PAID WITHIN 45 DAYS AFTER RECEIPT OF THE
10 CLAIM BY THE HEALTH PLAN. FOR A PHARMACEUTICAL CLEAN CLAIM, THE
11 CLEAN CLAIM MUST BE PAID WITHIN THE INDUSTRY STANDARD TIME FRAME
12 FOR PAYING THE CLAIM AS OF THE EFFECTIVE DATE OF THIS SUBDIVISION
13 OR WITHIN 45 DAYS AFTER RECEIPT OF THE CLAIM BY THE HEALTH PLAN,
14 WHICHEVER IS SOONER. A CLEAN CLAIM THAT IS NOT PAID WITHIN THIS
15 TIME FRAME SHALL BEAR SIMPLE INTEREST AT A RATE OF 12% PER
16 ANNUM.

17 (F) THAT A HEALTH PLAN MUST STATE IN WRITING TO THE HEALTH
18 PROFESSIONAL OR FACILITY ANY DEFECT IN THE CLAIM WITHIN 30 DAYS
19 AFTER RECEIPT OF THE CLAIM.

20 (G) THAT A HEALTH PROFESSIONAL AND A HEALTH FACILITY HAVE 30
21 DAYS AFTER RECEIPT OF A NOTICE THAT A CLAIM OR A PORTION OF A
22 CLAIM IS DEFECTIVE WITHIN WHICH TO CORRECT THE DEFECT. THE
23 HEALTH PLAN SHALL PAY THE CLAIM WITHIN 30 DAYS AFTER THE DEFECT
24 IS CORRECTED.

25 (H) THAT A HEALTH PLAN MUST NOTIFY THE HEALTH PROFESSIONAL
26 OR FACILITY OF THE DEFECT, IF A CLAIM OR A PORTION OF A CLAIM IS
27 RETURNED FROM A HEALTH PROFESSIONAL OR FACILITY UNDER SUBDIVISION

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1 (G) AND REMAINS DEFECTIVE FOR THE ORIGINAL REASON OR A NEW
2 REASON.

3 (I) THAT A HEALTH PLAN MUST REPORT TO THE COMMISSIONER THE
4 NUMBER OF CLAIMS THAT HAVE NOT BEEN PAID WITHIN THE TIME LIMITS
5 PRESCRIBED IN THIS SECTION. THE REPORT IS DUE ON JANUARY 1,
6 APRIL 1, JULY 1, AND OCTOBER 1 OF EACH YEAR. HOWEVER, A REPORT
7 IS NOT DUE DURING THE 6-MONTH PERIOD FOLLOWING THE EFFECTIVE DATE
8 OF THE AMENDATORY ACT THAT ADDED THIS SUBDIVISION.

9 (J) PENALTIES TO BE APPLIED TO HEALTH PROFESSIONALS, HEALTH
10 FACILITIES, AND HEALTH PLANS FOR FAILING TO ADHERE TO THE TIMELY
11 CLAIMS PAYMENT PROCEDURE ESTABLISHED UNDER SUBSECTIONS (7) TO
12 (12).

13 (K) THAT IF A HEALTH PLAN, HEALTH PROFESSIONAL, OR HEALTH
14 FACILITY DISAGREES WITH THE PENALTY IMPOSED BY THE COMMISSIONER
15 OR HIS OR HER DESIGNEE UNDER SUBDIVISION (J), THE COMMISSIONER OR
16 HIS OR HER DESIGNEE SHALL PROCEED TO HEAR THE MATTER AS A CON-
17 TESTED CASE UNDER THE ADMINISTRATIVE PROCEDURES ACT OF 1969, 1969
18 PA 306, MCL 24.201 TO 24.328.

19 (L) A SYSTEM FOR NOTIFYING THE LICENSING ENTITY IF A PENALTY
20 IS INCURRED UNDER SUBDIVISION (J).

21 (M) AN EXTERNAL REVIEW PROCEDURE FOR ADVERSE DETERMINATIONS
22 OF PAYMENT. THE COSTS FOR THE EXTERNAL REVIEW ESTABLISHED UNDER
23 THIS SUBDIVISION SHALL BE ASSESSED AS DETERMINED BY THE
24 COMMISSIONER.

25 (10) IF A HEALTH PLAN DETERMINES THAT 1 OR MORE SERVICES
26 LISTED ON A CLAIM ARE PAYABLE, THE HEALTH PLAN SHALL PAY FOR
27 THOSE SERVICES AND SHALL NOT DENY THE ENTIRE CLAIM BECAUSE 1 OR

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1 MORE OTHER SERVICES LISTED ON THE CLAIM ARE DEFECTIVE. THIS
2 SUBSECTION DOES NOT APPLY IF A HEALTH PLAN AND HEALTH PROFES-
3 SIONAL OR HEALTH FACILITY HAVE AN OVERRIDING CONTRACTUAL REIM-
4 BURSEMENT ARRANGEMENT.

5 (11) THE COMMISSIONER SHALL REPORT TO THE SENATE AND HOUSE
6 OF REPRESENTATIVES STANDING COMMITTEES ON HEALTH AND INSURANCE
7 ISSUES BY OCTOBER 1, 2001 ON THE TIMELY CLAIMS PROCESSING AND
8 PAYMENT PROCEDURE ESTABLISHED UNDER SUBSECTIONS (7) TO (12).

9 (12) AS USED IN SUBSECTIONS (7) TO (11), "HEALTH PLAN" MEANS
10 ALL OF THE FOLLOWING:

11 (A) AN INSURER PROVIDING BENEFITS UNDER AN EXPENSE-INCURRED
12 HOSPITAL, MEDICAL, SURGICAL, VISION, OR DENTAL POLICY OR CERTIFI-
13 CATE [AND PURSUANT TO A DIRECT CONTRACT BETWEEN AN INSURER AND A
HEALTH PROFESSIONAL OR HEALTH FACILITY], INCLUDING ANY POLICY OR
CERTIFICATE THAT PROVIDES COVERAGE
14 FOR SPECIFIC DISEASES OR ACCIDENTS ONLY, OR ANY HOSPITAL INDEMNI-
15 TY, MEDICARE SUPPLEMENT, LONG-TERM CARE, DISABILITY INCOME, OR
16 1-TIME LIMITED DURATION POLICY OR CERTIFICATE [, BUT NOT INCLUDING
AN INSURER WITH RESPECT TO A POLICY OR CERTIFICATE FOR AN EMPLOYER
THAT HAS A SELF-FUNDED HEALTH CARE BENEFIT PLAN].

17 (B) A MEWA REGULATED UNDER CHAPTER 70 THAT PROVIDES HOSPI-
18 TAL, MEDICAL, SURGICAL, VISION, DENTAL, AND SICK CARE BENEFITS
[, BUT NOT INCLUDING A MEWA THAT HAS AN EMPLOYER MEMBER WITH A SELF-
FUNDED HEALTH CARE BENEFIT PLAN].

19 (C) A HEALTH MAINTENANCE ORGANIZATION LICENSED OR ISSUED A
20 CERTIFICATE OF AUTHORITY IN THIS STATE [, BUT NOT INCLUDING A HEALTH
MAINTENANCE ORGANIZATION WITH RESPECT TO A CONTRACT FOR AN EMPLOYER
THAT HAS A SELF-FUNDED HEALTH CARE BENEFIT PLAN].

21 (D) A HEALTH CARE CORPORATION FOR BENEFITS PROVIDED UNDER A
22 CERTIFICATE ISSUED UNDER THE NONPROFIT HEALTH CARE CORPORATION
23 REFORM ACT, 1980 PA 350, MCL 550.1101 TO 550.1704 [, BUT NOT
INCLUDING A HEALTH CARE CORPORATION WITH RESPECT TO A CERTIFICATE
FOR AN EMPLOYER THAT HAS A SELF-FUNDED HEALTH CARE BENEFIT PLAN AND
NOT TO PAYMENTS MADE PURSUANT TO AN ADMINISTRATIVE SERVICES ONLY OR
COST-PLUS ARRANGEMENT].

24 Enacting section 1. This amendatory act takes effect on
25 January 1, 2001 and applies to all health care claims submitted
26 for payment on and after January 1, 2001.