SENATE BILL NO. 693

September 21, 1999, Introduced by Senator SCHUETTE and referred to the Committee on Health Policy.

A bill to provide for payment of certain health care claims; to prescribe the powers and duties of certain state agencies and officers; and to prescribe certain penalties.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. This act shall be known and may be cited as the "timely payment of health care claims act".

Sec. 3. As used in this act:

(a) "Claim payment amount" means the amount that a health care payor is liable to pay on a health care claim.

(b) "Claimant" means a person who submits a health care claim to another person, including a covered person or health care provider.

(c) "Clean claim" means a health care claim that can be processed in accordance with a health care payor's reasonable

procedures without the obtaining of additional information from the claimant or any other person.

(d) "Health care claim" means a request for the payment of hospital, medical, surgical, vision, dental, or sick care benefits or services.

(e) "Health care payor" means a person who pays on or reimburses any part of the cost of a health care claim provided to a covered person, including an employer, a group of employers, any plan established by an employer or employer group, or any person who maintains or operates a network or panel of health care providers. Health care payor does not include any of the following:

(*i*) A health care provider, group medical practice, physician organization, physician/hospital organization, or other similar entity.

(*ii*) An individual who pays for any part of the cost of hospital, medical, surgical, vision, dental, or sick care benefits or services provided to the individual or a family member of the individual.

(f) "Health care provider" means a person licensed, certified, or registered under part 62 or parts 161 to 183 of the public health code, 1978 PA 368, MCL 333.6201 to 333.6251 and 333.16101 to 333.18311, or a health facility.

(g) "Health facility" means:

(*i*) A facility or agency licensed or authorized under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.

(*ii*) A mental hospital, psychiatric hospital, psychiatric unit, or mental retardation facility operated by the department of mental health or certified or licensed under 1974 PA 258, MCL 330.1001 to 330.2106.

(*iii*) A facility providing outpatient physical therapy services, including speech pathology services.

(*iv*) A kidney disease treatment center, including a free-standing hemodialysis unit.

(*v*) An organized ambulatory health care facility.

(*vi*) A tertiary health care service facility.

(*vii*) A substance abuse treatment program licensed under parts 61 to 65 of the public health code, 1978 PA 368, MCL 333.6101 to 333.6523.

(*viii*) An outpatient psychiatric clinic.

(*ix*) A home health agency.

Sec. 5. This act applies to all persons who are health care payors except for payors of a health care claim as defined in section 2006a of the insurance code of 1956, 1956 PA 218, MCL 500.2006a.

Sec. 7. Except as otherwise provided in section 11, a health care payor shall pay in full the claim payment amount for a health care claim, or any undisputed part of a health care claim, as follows:

(a) Within 30 days following receipt of a clean claim by electronic transmission.

(b) Within 45 days following receipt of a clean claim by hard copy.

Sec. 9. A health care claim shall be considered a clean claim, unless a health care payor, within 30 days following receipt of a claim by electronic transmission or within 45 days following receipt of a claim by hard copy, requests in writing from the claimant all additional information, if any, reasonably needed to determine liability to pay the health care claim. Upon the health care payor's receipt of all additional requested information, the health care claim shall be considered a clean claim. A health care payor that requests additional information that is not reasonably needed to determine liability to pay a health care claim is liable for the payment of interest as provided in section 19.

Sec. 11. A health care payor shall pay a clean claim within the applicable 30- and 45-day time periods prescribed in section 7(a) and (b) unless the health care payor reasonably disputes its obligation to pay the clean claim, in whole or in part, based on 1 or more of the following grounds:

(a) The eligibility of a person for coverage.

(b) The liability of another person for all or part of the claim.

(c) The amount of the claim.

(d) The covered benefits.

(e) The manner in which services were accessed or provided.

(f) That the claim was submitted fraudulently so long as there is a reasonable basis supported by specific information available for review by the insurance commissioner to support this belief.

Sec. 13. Following receipt of a clean claim and within the applicable 30- and 45-day time periods prescribed in section 7(a) and (b), a health care payor that disputes its obligation to pay a clean claim, in whole or in part, shall notify the claimant in writing that it is not obligated to pay some or all of the claim stating with specificity all reasons why it is not liable. A health care payor that unreasonably disputes liability to pay a claim or that violates section 11 is liable for the payment of interest as provided in section 19.

Sec. 15. Each health care claim processed in violation of this section constitutes a separate violation. A health care payor is responsible to ensure that any person that processes health care claims on its behalf complies with this act.

Sec. 17. If, after opportunity for a hearing held pursuant to the administrative procedures act of 1969, 1969 PA 306, MCl 24.201 to 24.328, the insurance commissioner determines that a health care payor has violated this act, the insurance commissioner shall reduce his or her findings and decision to writing and shall issue and cause to be served upon the health care payor a copy of the findings and an order requiring the health care payor to cease and desist from violating this act and shall order payment of a monetary penalty of $5,000.00 for each violation.

Sec. 19. A health care payor that violates section 7, 9, 11, or 13 shall pay the claimant interest on the claim payment amount computed at the rate of 18% per annum from the date on which the claim payment amount was required to be paid until the date on which the claim payment amount is paid in full. Interest

shall be paid at the time the claim payment amount is paid in full.

Sec. 21. A covered person or claimant may bring a civil action against a health care payor to recover the claim payment amount and interest payable under section 19, together with actual attorney fees and litigation expenses and costs. This section does not abrogate or impair any other legal or equitable action, claim, or remedy that a covered person or claimant may have against a health care payor.

Sec. 23. A health care provider whose membership on any provider panel is terminated by or for a health care payor shall be provided with a written explanation of all reasons for the termination. The person who maintains the panel shall furnish the explanation to the health care provider when the health care provider is given notice of termination.

Sec. 25. A person shall not terminate the participation of a health care provider on any provider panel, or otherwise discriminate against a health care provider, because the health care provider claims that a person has violated this act. A health care provider who alleges a violation of this section may bring a civil action for appropriate injunctive relief, damages, or both, together with actual attorney fees and litigation expenses and costs.

Enacting section 1. This act takes effect on January 1, 2000 and applies to all health care claims submitted for payment on and after January 1, 2000.