House
Legislative
Analysis
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TIMELY PAYMENT OF HEALTH CARE BENEFITS

Senate Bills 451 (Substitute H-1)
Senate Bill 452 as passed by the Senate
First Analysis (2-12-02)

Sponsor: Sen. Bill Schuette
House Committee: Insurance and Financial Services
Senate Committee: Health Policy

THE APPARENT PROBLEM:

Reportedly, health professionals and health facilities often wait months for payment from insurers and managed care plans. Some believe that the insurers are engaging in practices designed to slow down the disbursement of payments so that the insurer can hold on to payment funds for investment purposes or to beef up cash flow. Regardless of what factors may be behind such delayed payments, many health providers maintain that they are experiencing financial difficulties because insurance reimbursements are not being paid on a timely basis. Some health care providers also maintain that money that should be spent on hiring more medical staff and increasing the quality of care for patients is instead being spent on administrative staff and attempts to collect from insurers. One group practice reportedly had to increase its clerical staff from 6 to 16 and add two billing specialists just to handle late payments and rejections from insurers. According to health care providers, the problem is so pervasive that some report that even clean claims (those without informational errors or omissions) submitted for payment to insurers usually take about two to three months for reimbursement, and it is not uncommon to have some claim payments exceed 90 days and longer, with some health care providers reporting payments that took 18 months and more.

The problem is not unique to Michigan. In fact, in recent years, 38 states have enacted legislation to deal with delayed payments from insurers, and state regulators are cracking down on offenders. According to an article in the American Medical News (April 17, 2000), in response to complaints that health maintenance organizations (HMOs) weren't following Georgia law requiring timely payments, the insurance commissioner began to require that HMOs submit quarterly claims data. The quarterly review plan has already led to one large HMO being fined over a quarter of a million dollars for late claims payments. Many within the health care industry believe that Michigan should also adopt laws to establish a timely claims payment procedure.

THE CONTENT OF THE BILLS:

The bills would require the establishment of a timely claims processing and payment procedure to be used by health professionals and health facilities, and by health insurers, health maintenance organizations, and Blue Cross and Blue Shield of Michigan. The bills would take effect on October 1, 2002 and would apply to all health care claims with dates of service on and after that date.

Specifically, the bills would do the following:

Senate Bill 451 would amend the Insurance Code (MCL 500.2006) to establish a timely claims processing and payment procedure to be used by health professionals and health facilities in billing for, and health plans in processing and paying claims for, services rendered.

Currently, Section 2006 of the Insurance Code requires insurers to pay benefits under a contract of insurance, on a timely basis. 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, unless there is no recipient who can legally give a valid release for the payment, or the insurer is unable to determine who is entitled to receive payment. The insured is entitled to interest at 12 percent 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 when paying claims to health professionals and facilities (that are not pharmacies) that did not involve claims arising out of a section pertaining to motor vehicle protection or the Worker's Disability Compensation Act, and would instead institute new requirements for health plans (see below). Further, the timely claims processing and payment procedures established under the bill would not apply to an entity regulated under the Worker's Disability Compensation Act, nor to the processing and paying of Medicaid claims that are covered under Section 111i of the Social Welfare Act.

"Health professional" would mean a licensed or registered health professional under Article 15 of the Public Health Code and "health facility" would be health facility or agency licensed under Article 17 of the Public Health Code. "Health plan" would mean 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, or one-time limited duration policy or certificate, but not to payments made to an administrative services only [ASO] or cost-plus arrangement); a MEWA regulated under Chapter 70 of the code that provides hospital, medical, surgical, vision, dental, and sick care benefits; an HMO licensed or issued a certificate of authority in this state; and Blue Cross Blue Shield of Michigan (BCBSM) for benefits provided under a certificate issued under the Nonprofit Health Care Corporation Reform Act, but not to payments made under an ASO, or cost-plus arrangement. The bill would not apply to an entity regulated under the Worker's Disability Compensation Act. The provisions would apply to health plans when paying claims to health professionals and facilities (that are not pharmacies) that did not involve claims arising out of a section pertaining to motor vehicle protection or the Worker's Disability Compensation Act.

Clean Claim. A "clean claim" would be a claim that did all of the following:

- Identified the health professional or health facility that provided service sufficiently to verify affiliation status and would include any identifying numbers;

- sufficiently identified the patient and health plan subscriber;

- listed the date and place of service;

- was for covered services for an eligible individual;

- 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 information sufficient to establish that prior authorization had been obtained;

- identified the service rendered using a generally accepted system of procedure or service coding; and,

- included additional documentation based upon services rendered as reasonably required by the health plan.

Timely payment procedure. Each health professional and health facility in billing for services rendered and each health plan in processing and paying claims for services rendered would have to use the following timely processing and payment procedures:

- A clean claim would have to be paid within 45 days after the health plan received it. A clean claim not paid within the time frame would bear simple interest at the rate of 12 percent per year;

- A health plan would have to notify the health professional or facility within 30 days after receiving a claim of all known reasons that prevent the claim from being a clean claim.

- A health professional or health plan would have at least 45 days after receiving a notice to correct all known defects. The 45-day period in which claims are to be paid would be tolled (the counting of days would stop) from the date of receipt of a notice to a health professional or facility to the date of the health plan's receipt of a response from the health professional or facility.

- If the health professional's or facility's response made the claim a clean claim, the health plan would have to pay the claim within the 45-day time period as required by the bill, excluding any time period that was tolled during which a health professional or facility was notified of a defect in the claim and while the claim was being corrected.

- If the response by the health professional or facility did not make the claim a clean one, the health plan would have to notify the health professional or facility of an adverse claim determination and of the reasons for such a determination within the 45-day time period, excluding any time period that was

tolled during which a health professional or facility was notified of a defect in the claim and while the claim was being corrected.

• In order for a claim to be a "clean claim", a health professional or health facility would have to bill a health plan within one year after the date of service or the date of discharge from the health facility.

• The health professional or health facility could not resubmit the same claim to the health plan unless the 45-day processing and payment period had passed, including the time period allowed for correcting a claim.

• Notices required under the bill would have to be made in writing or electronically.

If a health plan determined that one or more covered services listed on a claim were payable, the health plan would have to pay for those services and not deny the entire claim because other services listed on the claim were defective. This provision would not apply if the health plan and health professional or health facility had an overriding contractual reimbursement arrangement. Additionally, if a health professional or facility claimed that a health plan violated the timely processing and payment procedure, the health plan could not terminate the affiliation status or the participation of the health professional or facility with an HMO provider panel or otherwise discriminate against them.

Penalties. If a health professional, health facility, or health plan believed that the timely processing and payment procedure under the bill had been violated by one of the other entities, a complaint could be filed with the commissioner on an approved form, and the complainant would have a right to a determination by the commissioner or his or her designee. The commissioner could, in addition to any other penalty provided by law, impose a civil fine on a provider, facility, or plan of not more than $1,000 for each violation of the timely processing and payment procedures. If there were multiple violations, the total fine could not exceed $10,000.

A health professional, facility, or plan could also seek court action. However, a BCBSM health plan would be subject only to the procedures and penalties provided in Section 402 of the Nonprofit Health Care Corporation Reform Act (MCL 550.1402) and the imposition of a civil fine by the commissioner.

Senate Bill 452 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1403), which regulates Blue Cross and Blue Shield of Michigan (BCBSM), to provide that the provisions of Senate Bill 451 would apply to BCBSM, and to specify that when BCBSM was paying a claim under the timely processing and payment procedures provisions of Senate Bill 451, certain provisions in the BCBSM act, which require BCBSM to specify what constitutes a satisfactory claim within 30 days of receiving a claim, would not apply. The bill is tie-barred to Senate Bill 451.

HOUSE COMMITTEE ACTION:

The House Committee amended Senate Bill 451 to:

• Delete a provision requiring that within two years, claims would have to be submitted electronically, and health plans would have to be able to receive electronic submissions.

• Specify that the timely processing and payment procedures created under the bill would not apply to Medicaid claims.

• Prohibit duplicate submissions of a claim until after the 45-day period has expired.

• Require a health professional or health facility to bill a health plan within one year of the date of service or date of hospital discharge in order for the claim to be considered a clean claim.

BACKGROUND INFORMATION:

The bills are similar to Senate Bills 694 and 696 of the 1999-2000 legislative session. The bills were ordered enrolled, but were vetoed by the governor. In his veto message, the governor wrote that the bill package represented "a legislative attempt to micromanage existing contracts between two private parties", and that contract enforcement was, "from a constitutional perspective," rightfully left to the judicial branch. The governor also cited cost concerns as a reason to veto the bill package; e.g., that Senate Bill 694 had "the potential to increase the size of state government by a least 20 FTEs and up to 2,000 FTEs depending on the number of disputed claims."

Another bill, enrolled Senate Bill 938 of 2000, which became Public Act 187 of 2000, amended the Social Welfare Act to establish a timely claims processing and payment procedure to be used by health professionals and facilities in billing, and by qualified health plans in paying claims, for Medicaid services rendered. (For more information, see the Senate

Fiscal Agency's analysis of Senate Bill 938 dated 3-12-01.) In his veto message for Senate Bill 694, the governor distinguished between the two bills by writing that PA 187 "dealt exclusively with the payment of Medicaid services by the state to health care providers." Therefore, according to the governor, the "appropriate role of state government was instituting a claims process for Medicaid services."

FISCAL IMPLICATIONS:

According to an analysis prepared by the Office of Financial and Insurance Services (OFIS), the bill package would place increased duties upon OFIS, and more staff time would be needed to review and enforce the penalties associated with violations contained in the legislation. That activity would take staff away from other necessary functions unless OFIS was able to add staff to perform these new functions. (2-6-02)

ARGUMENTS:

For:

Health care providers across the state are complaining about the increasingly difficult task of receiving payments for claims in a timely manner. Some offices have been forced to increase their administrative staff, even hire billing specialists, to track unpaid claims and battle with health insurers in order to get paid for covered services. This situation is problematic for several reasons. Doctors must spend an increasing amount of time with their billing staff to answer questions in regards to rejected claims, instead of spending that time providing care to patients. Revenue that could be spent on newer medical equipment, hiring additional medical personnel, and so forth, must instead be spent on hiring additional administrative staff to deal with the amount of unpaid claims. Further, health care providers can be in the situation where a substantial amount of operating capital can be tied up in pending claims, thus placing their practices in a financially precarious place. Mounting debts from backlogs in reimbursements from services already rendered threaten many medical practices and health facilities. Reportedly, one doctor had to charge $20,000 to his personal credit card account in order to make his payroll and pay other office expenses.

Part of the problem lies in the lack of a consistent definition of what constitutes a clean claim. Providers often feel that claims are rejected as defective when that is not the case, necessitating rebilling and resulting in another long wait to receive payment. Further, there is little recourse for providers if a health plan or insurer is consistently slow in responding to paying claims, or for a health plan if a provider is slow in correcting claims or submits many duplicate claims. Senate Bill 451 and its companion bill would help remedy the situation by creating a timely claims processing and payment procedure. The bills would focus on those claims that are not disputed. Under Senate Bill 451, the term "clean claim" would be defined, and penalties would be levied on providers or insurers who do not comply with the provisions for timely submission and payment of claims. The provision prohibiting providers from submitting duplicate claims until after the original 45-day period for payment has expired should greatly reduce the number of claims declared to be defective and speed up the claims process by eliminating duplications that can bog down the system. Those plans, or providers, who consistently were found to be in noncompliance with the timely claims process could face fines or be taken to court. In short, as a whole, the bill package creates a mechanism by which insurance claims should be processed more quickly and consistently. In addition to helping health plans and providers, a major benefit of quicker claims payment and fewer disputed claims could be that both providers and insurers see a cost savings that could be passed on to consumers.

For:

Under the bills, the time lines for timely payment can be "tolled" while a claim is being corrected by a health professional or health facility. This means that the clock is stopped once a provider or facility receives notice that a submitted claim is not a clean claim – meaning that it is missing important information. The 45-day clock would not be started again until the health plan received the corrected information from the provider or facility. This provision would encourage the health plans as well as the doctors' offices and health facilities to respond to each other in a quick and timely fashion. The health plans would want to respond quickly to avoid penalties under the bill and providers would want to respond quickly to facilitate quicker reimbursements.

Against:

The bills are not needed. The governor vetoed bills that were similar in concept based on cost concerns and also that such legislation represents a governmental intrusion on contractual agreements between private parties. Instead of such a costly legislative response, health plans should be encouraged to negotiate acceptable timely claims

processing and payments clauses in their contracts with health providers and health facilities. Providers already sign contracts with health plans that spell out how claims are to be handled. A provider contract would be a more efficient vehicle in which to correct inequities. If a plan does not pay claims quickly or resolve disputes fairly, the plan may lose so many doctors on its panel that it could not continue to meet statutory levels of provider service for a particular geographic area and would be forced out of business.

Response:

Contracts between health providers or health facilities and health plans (insurance companies) are not like other business contracts. Health plans have provider panels, and a doctor or hospital must be accepted by the health plan to be on a panel. It is the health plan, and not the health provider or facility, that holds all the cards in negotiations. In fact, many providers maintain that "negotiations" don't really exist in this realm, as they are told to "take what is offered or leave it." "Leaving it", however, means that the provider or facility wouldn't be on a particular health plan panel, and therefore most likely would lose any patients with that health plan.

Regarding the governor's veto of the earlier legislation, many of those concerns have been addressed in Senate Bill 451. The earlier bill, Senate Bill 694 of 2000, would have placed many burdens on the commissioner of OFIS. For instance, the earlier legislation would have required the commissioner to develop the procedure for timely processing and payment of claims after consulting with the Department of Community Health, health professionals and facilities, and health plans (which would have included the development of a universal system of coding); review quarterly reports submitted by health plans on the number of claims that had not been paid within the time limits; annually report to certain House and Senate standing committees on the timely claims processing and payment procedure; notify the licensing agency of any penalties imposed on providers and hospitals; and, if any entity disagreed with the imposed penalty, hear the matter as a contested case under the Administrative Procedures Act.

Senate Bill 451 has reduced and streamlined the commissioner's oversight duties. Any associated costs to create a timely processing and payment system would likely be minimal as compared to the past attempt. Further, the bills do not appear to overly interfere with any contractual arrangements existing between health care providers and health plans.

Against:

The bill would not apply to administrative services only contracts (ASO contracts). ASO services are, in general, administrative services such as claims processing provided for a self-insured health benefit plan. Such self-insured plans, which cover a great many people in Michigan, are generally preempted from state regulation under federal ERISA laws (the Employee Retirement Income Security Act that regulates employee pension and benefit plans). Therefore, the bill would not apply to claims filed on behalf of the majority of insured persons within the state.

Further, as the bill specifies that it applies to health plans "when paying claims to health professionals and facilities", it is likely that it would not apply to those health plans that only reimburse the individual who purchases a health plan out-of-pocket or when an insured goes to a physician or facility that does not participate in his or her health plan and so receives reimbursement directly from the health plan.

Response:

The current law allows any insured person to collect 12 percent interest on claims that have not been paid within 60 days after the insurance received the claim. Therefore, relief already exists for the individual who must bill directly to his or her health plan.

Against:

The Senate-passed version of Senate Bill 451 would have required health care providers, within two years, to submit claims electronically if they wanted to take advantage of the timely claims processing and payment procedure. This provision was removed by a House committee amendment, the rationale being that small or rural practices may not have the capability or the technological know how to transmit claims electronically, and therefore should not be excluded from participation in the timely claims procedure. According to insurers, however, a paper claim requires more time to process than an electronic submission. Paper claims are more labor intensive and need hands-on processing, unlike electronic billing for which software applications can be developed to complete many of the processing tasks. Considering the sheer number of claims that insurers process on a regular basis, it would be difficult to process a large number of paper claims within the 45-day time period specified in the bill. Therefore, without the requirement that claims be submitted electronically within the near future, health insurers could be unfairly disadvantaged under the bill and face a greater possibility of being subjected to the bill's penalties.

Health insurers also note that federal regulations will require insurers to utilize a uniform coding system, possibly beginning in October of 2003. If providers do not comply with the new uniform coding system, even more may submit paper claims rather than updating their electronic capabilities. If this were to happen, insurers could be faced with increasingly larger numbers of paper claims to try to process within the 45-day time period. Yet, failure to do so within the prescribed 45-day period could subject the health plans to fines and possible tort action. Since computers are more reasonably priced and most workers already have a working knowledge of computers, it does not appear to be a hardship to specify that the timely claims processing and payment procedures should apply only to electronic submissions. Those who wish to submit paper claims could still do so; however, those claims would not fall within the 45-day requirement for processing and payment

Against:

There are several remaining concerns with Senate Bill 451 that have been raised by those in the health and insurance industries, including the following:

- The sheer scope of the number of financial transactions that could be involved could prove daunting. In 1995, approximately $30 billion in medical claims were processed. If even a fraction of those claims were appealed to the commissioner for resolution, it could overwhelm the Division of Insurance's capabilities to monitor and implement the bill's provisions.

- The bills could prove very costly to implement. Enactment of this package could further add to the duties of the commissioner of OFIS, which anticipates a possible need for additional staff if many complaints are filed with the commissioner. It would be hard to pass this entire cost on to providers or insurers. Sooner or later, it is going to be the consumer who bears the brunt in increased medical and health insurance costs or higher taxes to support additional OFIS staff.

- The bill would require a health care provider to refrain from double billing for the same service during the 45-day time frame established in Senate Bill 451. The insurers report that such double billing bogs down their systems and could hinder their attempts at compliance with the established time frame for payment. However, according to a hospital association representative, many hospitals utilize an automated billing system both for patient billing and for billing health plans that sends out monthly statements. It would appear that solving a problem for one industry member could create problems for another.

- The bills represent yet another legislative attempt to have a state agency superimpose itself on a contract between two private parties.

POSITIONS:

The Michigan Health & Hospital Association supports the bills. (2-8-02)

The Michigan Chiropractic Society supports the bills. (2-7-02)

The Michigan Osteopathic Association (MOS) supports the bills. (2-7-02)

The Michigan Academy of Physician Assistants supports the bills. (2-7-02)

The Michigan Dental Association supports the bills. (2-7-02)

The American College of Obstetricians and Gynecologists (ACOG) supports the bills. (2-7-02)

The Michigan Orthopaedic Society supports the bills. (2-7-02)

A representative of the Michigan State Medical Society testified in support of the bills. (1-30-02)

Blue Cross and Blue Shield of Michigan is neutral on the bills. (2-7-02)

The Office of Financial and Insurance Services does not oppose the bills. (2-6-02)

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.