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 Bills 451 and 452 (as enrolled) **PUBLIC ACTS 316 & 317 of 2002**
Sponsor: Senator Bill Schuette
Senate Committee: Health Policy
House Committee: Insurance and Financial Services

Date Completed: 1-15-03

CONTENT

Senate Bill 451 amended the Insurance Code to do the following:

-- Require health plans and health providers to use "timely processing and payment procedures", under which a health plan must pay a clean claim within 45 days after receiving it, or pay interest at a 12% annual rate.
-- Prohibit a health plan from denying an entire claim if one or more services listed on the claim are payable, unless the health plan and health provider have an overriding contractual reimbursement arrangement.
-- Prohibit a health plan from terminating the affiliation status or the participation of a health professional or health facility with a health maintenance organization provider panel, or otherwise discriminating against a health provider, because the professional or facility claims that the health plan has violated the bill.
-- Allow a health professional, health facility, or health plan alleging that a timely processing or payment procedure has been violated to file a complaint with the Commissioner of the Office of Financial and Insurance Services (OFIS).
-- Allow the OFIS Commissioner, in addition to any other penalty provided for by law, to impose a civil fine for violations of the bill.

Senate Bill 452 amended the Nonprofit Health Care Corporation Reform Act, which regulates Blue Cross and Blue Shield of Michigan (BCBSM), to specify that the provisions of the Insurance Code detailed in Senate Bill 451 apply to BCBSM; and provide that when BCBSM pays a claim under the Code, provisions in the Act that require BCBSM to specify what constitutes a satisfactory claim within 30 days of receiving a claim, do not apply.

The bills were tie-barred to each other. They took effect on October 1, 2002 and apply to health care claims with dates of service on or after that date.

A more detailed description of Senate Bill 451 follows.

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. The time period is extended if there is no recipient who can legally give a valid release for the payment, or if the insurer is unable to determine who is entitled to receive payment. The insured is entitled to interest at 12% 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 specifies that these provisions do not apply to health plans when paying claims to health professionals and health facilities that are not pharmacies and that do not involve claims arising out of the Worker's Disability Compensation Act or sections of the Insurance Code that regulate motor vehicle personal and property protection.

Under the bill, each health professional and health facility in billing for services rendered, and each health plan in processing and paying claims for services rendered, must use the following "timely processing and payment procedures":

-- A clean claim must be paid within 45 days after the health plan receives it. A clean claim that is not paid within 45 days bears simple interest at a rate of 12% per year.
-- A health plan must notify a health provider, within 30 days after receiving the claim, of all known reasons that prevent it from being a clean claim.
-- A health provider has 45 days after receiving notice of a defective claim, and any additional time allowed by the health plan, to correct all known defects. The 45-day period for the health plan to pay a clean claim will be tolled from the date the provider receives notice of defects to the date the health plan receives a response from the provider.
-- If a health provider's response makes the claim a clean claim, the health plan must pay the provider within the 45-day period to pay a clean claim, excluding any period tolled.
-- If the health provider's response fails to make the claim a clean claim, the health plan must notify the provider of an adverse claim determination and the reasons for it within the 45-day period for the health plan to pay a clean claim, excluding any period tolled.

The notices required in these provisions must be made in writing or electronically.

The bill defines "clean claim" as a claim that does all of the following:

-- Identifies the health professional or health facility that provided service sufficiently to verify affiliation status, including any identifying numbers.
-- Sufficiently identifies the patient and health plan subscriber.
-- Lists the date and place of service.
-- Is a claim for covered services for an eligible individual.
-- If necessary, substantiates the medical necessity and appropriateness of the service provided.
-- If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
-- Identifies the service rendered using a generally accepted system of procedure or service coding.
-- Includes additional documentation based upon services rendered as reasonably required by the health plan.

Additionally, a health professional or health facility must bill a health plan within one year after the date of service or the date of discharge from the facility in order for the claim to be clean. A provider may not resubmit a claim unless the time frame described above has passed.

A health professional, health facility, or health plan alleging that a timely processing or payment procedure has been violated may file a complaint with the OFIS Commissioner, and has the right to a determination on the matter by the Commission or his or her designee. The bill specifies that this provision does not prohibit a health provider or health plan from seeking court action. If the OFIS Commissioner determines that a violation has occurred, he or she may impose a civil fine of up to $1,000 for each violation not to exceed $10,000 in the aggregate for multiple violations.

The bill specifies that BCBSM is subject only to the procedures and penalties provided for in the bill and in Section 402 of the Nonprofit Health Care Corporation Reform Act, for a violation of a timely processing or payment procedure. (Section 402 prohibits BCBSM from engaging in certain acts, and prescribes penalties and remedies for violations.)

The bill defines "health plan" as all of the following:

-- An insurer providing benefits under an expense-incurred hospital, medical, surgical, vision, or dental policy or certificate, including any policy or certificate that provides coverage for specific diseases or accidents only, or any hospital indemnity, Medicare supplement, long-term care, disability income, or one-time limited duration policy or certificate, but not
-- A multiple employer welfare arrangement (MEWA) regulated under the Insurance Code that provides hospital, medical, surgical, vision, dental, and sick care benefits.

-- A health maintenance organization licensed or issued a certificate of authority in this State.
-- Blue Cross and Blue Shield of Michigan for benefits provided under a certificate issued under the Nonprofit Health Care Corporation Reform Act, but not to payments made to an administrative services only or cost-plus arrangement.

The timely payment and processing procedures do not apply to an entity regulated under the Worker's Disability Compensation Act or to the processing and payment of Medicaid claims that are covered under Section 111i of the Social Welfare Act. (That section requires the OFIS Commissioner to establish a timely claims processing and payment procedure to be used by health providers in billing, and health plans in processing and paying claims, for Medicaid services rendered.)

MCL 500.2006 (S.B. 451)
500.1403 (S.B. 452)

Legislative Analyst: Julie Koval

FISCAL IMPACT

These bills require the OFIS Commissioner to determine if a health plan has violated the clean claim payment procedures, following an administrative hearing. Violations may result in the imposition of fines, which will offset the costs of enforcing this section of the Insurance Code. There is currently no information available regarding how many of these hearings will result in a fine; therefore, the fiscal impact is indeterminate at this time.

Fiscal Analyst: Maria Tyszkiewicz

S0102\s451es