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SFA BILL ANALYSIS

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Senate Bills 451 and 452 (as introduced 5-3-01)
Sponsor: Senator Bill Schuette
Committee: Health Policy

Date Completed: 11-5-01

CONTENT

Senate Bill 451 would amend the Insurance Code to do the following:

-- Require a "health plan" and a "health provider" to follow a specified timely claims processing and payment procedure, which would include 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.
-- Require a health plan to make quarterly reports of claims not paid within the prescribed time limits.
-- Allow the Commissioner of the Office of Financial and Insurance Services to issue cease and desist orders and impose penalties, if he or she found that a health plan had engaged in a pattern of violations regarding claim payments.
-- Allow a health provider to bring a civil action against a health plan to recover claim payment amounts.

Senate Bill 452 would amend 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 proposed by Senate Bill 451 would apply to BCBSM; and provide that when BCBSM was paying a claim under the Code, certain provisions in the Act, which require BCBSM to specify what constitutes a satisfactory claim within 30 days of receiving a claim, would not apply.

The bills would take effect January 1, 2002, and would apply to all health care claims submitted for payment on or after that date. Senate Bill 452 is tie-barred to Senate Bill 451.

A more detailed description of Senate Bill 451 follows.

The bill would define "health plan" as any 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 provided 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; hospital, medical, surgical, vision, dental, and sick care benefits provided under a multiple employer welfare arrangement (MEWA) regulated under the Insurance Code; a health maintenance organization; or BCBSM. A "health provider" would be a health professional, health facility, or any entity consisting of health professionals or health facilities, not including a pharmacy.

Currently, Section 2006 of the Insurance Code requires insurers to pay benefits under a contract of insurance, on a timely basis. (This applies not just to health insurance, but to insurance in general.) 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 states that these provisions would not apply to health plans, when paying claims to health providers that did not arise out of claims under the Worker's Disability Compensation Act, or those provisions of the Insurance Code that regulate motor vehicle personal and property protection.

The bill would require a health plan to use the following "timely processing and payment procedures" when paying claims to health providers:

-- A clean claim would have to be paid within 45 days after the health plan received it. A clean claim that was not paid within 45 days would bear simple interest at a rate of 12% per year.
-- A health plan would have to state in writing to the health provider any defect in a claim, within 15 days after the health plan received it.
-- A health provider would have 30 days after receiving a notice that a claim or a portion of a claim was defective to correct the defect. The health plan would have to pay the claim within 30 days after the defect was corrected.
-- A health plan would have to notify the health provider of the defect, if a claim, or a portion of a claim, were returned from a health provider and remained defective for the original reason or a new reason.

Under the bill, a "clean claim" would be a claim that, at a minimum, satisfied the following:

-- Identified the health provider that provided treatment or service, including a matching identifying number.
-- Identified the patient and health plan subscriber.
-- Listed the date and place of service.
-- Was for covered services for an eligible individual.
-- If reasonably required by the health plan, substantiated the medical necessity and appropriateness of the care or service provided.

If a health plan determined that one or more services listed on a claim were payable, the health plan would have to pay for those services, and could not deny the entire claim because one or more other services listed on it were defective.

A health provider could bring a civil action against a health plan to recover a claim payment amount, interest, attorney fees, litigation expenses, and costs. The bill states that this provision would not abrogate or impair any other legal or equitable action, claim, or remedy that a health provider could have.

If, after an opportunity for a hearing held under the Administrative Procedures Act, the Commissioner determined that a health plan had engaged in a pattern of violating the requirements for a timely payment and processing procedure, the Commissioner would have to reduce his or her findings and decision to writing; issue and cause to be served upon the health plan a copy of the findings and an order requiring the health plan to cease and desist from violating the bill; and order payment of up to $5,000 for each violation, but not more than $50,000 in the aggregate for multiple violations. In addition, the Commissioner could order the suspension or revocation of the health plan's certificate of authority, if the health plan knowingly and persistently violated the bill.

A health plan would have to report to the Commissioner the number of claims that had not been paid within the time limits prescribed by the bill. The report would be due on January 1, April 1, July 1, and October 1 each year. (A report would not be due for the six months following the bill's effective date.)

A health provider whose membership on any provider panel was terminated, in whole or in part, would have to be given a written explanation of all reasons for the termination. The person who maintained the panel would have to furnish the explanation to the health provider when the provider was given notice of termination. A person could not terminate the participation of a health provider in any provider panel, or otherwise discriminate against a health provider, because the health provider claimed that the person had violated the provisions of the bill. A health provider that alleged a violation of this prohibition could bring a civil action for appropriate injunctive relief, damages, or both, together with actual attorney fees and litigation expenses and costs.

MCL 500.2006 (S.B. 451)
550.1403 (S.B. 452)

Legislative Analyst: G. Towne

FISCAL IMPACT

These bills would require the Commissioner of the Office of Financial and Insurance Services to determine if a health plan had violated the clean claim reimbursement procedure, following an administrative hearing. All violations would result in the implementation of fines, which would offset the costs of enforcing this section. There is currently no information available regarding how many of these hearings would result in a fine; therefore, the fiscal impact is indeterminate at this time.

Fiscal Analyst: M. Tyszkiewicz

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