Senate Fiscal Agency
P. O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 588 (Substitute S-1 as passed by the Senate)
Sponsor: Senator Shirley Johnson
Committee: Health Policy

Date Completed: 12-10-03

RATIONALE

Public Act 316 of 2002 amended the Insurance Code to provide for the proper submission of claims by health care providers, the timely payment of claims by insurers to health professionals and health facilities, a procedure for the resolution of disputes, and penalties for failure to comply with timely claim payment requirements. The Act was enacted in response to complaints from providers that they were not receiving timely reimbursement from health insurers and health plans for services rendered, placing financial strain on individual providers and the entire health care system. (The timely payment procedures are described below, under **BACKGROUND**.) It has been suggested that the timely payment procedures should be expanded to include payments to home health care providers and durable medical equipment providers, who also may experience delays in payment.

CONTENT

The bill would amend the Insurance Code to include home health care providers and durable medical equipment providers under provisions requiring timely payment of claims to health professionals and health facilities. The bill would take effect on June 1, 2004.

MCL 500.2006

BACKGROUND

The Insurance Code requires health plans to abide by the following requirements when processing claims by and paying claims to health professionals and health facilities that are not pharmacies and that do not involve claims arising out of Sections 3101 to 3177 of the Code (which deal with motor vehicle personal and property protection) or the Worker's Disability Compensation Act; and requires health professionals and health facilities to abide by the following procedures in billing for services rendered:

-- A clean claim must be paid within 45 days after receipt of the claim by the health plan. A clean claim that is not paid within 45 days bears simple interest at an annual rate of 12%.
-- A health plan must notify the provider within 30 days after receiving the claim of all known reasons that prevent it from being a clean claim.
-- A provider has 45 days, and any additional time the health plan permits, after receiving the notice to correct all defects in the claim.
-- If a provider's response makes the claim a clean claim, the health plan must pay the provider within the 45-day time period.
-- If a provider's response does not make the claim a clean claim, the health plan must notify the provider of an adverse claim determination and of the reasons for it within the 45-day time period.
-- A provider must bill a health plan within one year after the date of service or discharge from a health facility in order for a claim to be a clean claim.
-- A provider may not resubmit the same claim to the health plan unless the 45-day time period has passed.

Notices required under these provisions must be made either in writing or electronically.

If a health plan determines that at least one of the services listed on a claim is payable, the health plan must pay for the payable services and may not deny the entire claim because other services listed are defective. This

requirement does not apply if the provider has an overriding contractual reimbursement arrangement.

A health plan may not terminate the affiliation status or the participation of a provider with a health maintenance organization provider panel or otherwise discriminate against a provider because the provider claims that a health plan has violated the timely payment requirements. A provider alleging that a timely processing or payment procedure has been violated may file a complaint with the Commissioner of the Office of Financial and Insurance Services and has a right to determination of the matter by the Commissioner or his or her designee. A provider is not prohibited from seeking court action.

In addition to any other penalty provided for by law, the Commissioner may impose a civil fine of up to $1,000 for each violation not to exceed $10,000 in the aggregate for multiple violations.

A clean claim is one that is a claim for covered services for an eligible individual and does all of the following:

-- Identifies the provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
-- Sufficiently identifies the patient and health plan subscriber.
-- Lists the date and place of service.
-- 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.

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The quality of patient care may decline when health insurers and health plans routinely delay reimbursement to providers. Small practices might have difficulty covering overhead costs, such as salaries, utilities, and rent for office space. Health care providers and facilities also may feel great financial stress when they continue to provide services for which they are not compensated for months. The extra time and resources devoted to repeatedly submitting claims forms could be better directed to patient care. Like health professionals and facilities, providers of home health care and durable medical equipment are adversely affected by delayed payments, and should be included among the providers that insurers must reimburse in a timely manner.

Legislative Analyst: Julie Koval

FISCAL IMPACT

The bill would have no fiscal impact on State or local government.

Fiscal Analyst: Maria Tyszkiewicz

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