

HOUSE BILL No. 5908

May 13, 2004, Introduced by Reps. Taub, Ruth Johnson, Robertson, Vander Veen, Voorhees, Shaffer, Newell, Ehardt, Gillard, Pappageorge and Pastor and referred to the Committee on Insurance.

A bill to amend 1956 PA 218, entitled
"The insurance code of 1956,"
by amending section 2006 (MCL 500.2006), as amended by 2004 PA
28.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 2006. (1) A person must pay on a timely basis to its
2 insured, an individual or entity directly entitled to benefits
3 under its insured's contract of insurance, or a third party tort
4 claimant the benefits provided under the terms of its policy, or,
5 in the alternative, the person must pay to its insured, an
6 individual or entity directly entitled to benefits under its
7 insured's contract of insurance, or a third party tort claimant
8 12% interest, as provided in subsection (4), on claims not paid
9 on a timely basis. Failure to pay claims on a timely basis or to
10 pay interest on claims as provided in subsection (4) is an unfair

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1 trade practice unless the claim is reasonably in dispute.

2 (2) A person shall not be found to have committed an unfair
3 trade practice under this section if the person is found liable
4 for a claim pursuant to a judgment rendered by a court of law,
5 and the person pays to its insured, individual or entity directly
6 entitled to benefits under its insured's contract of insurance,
7 or third party tort claimant interest as provided in subsection
8 (4).

9 (3) An insurer shall specify in writing the materials that
10 constitute a satisfactory proof of loss not later than 30 days
11 after receipt of a claim unless the claim is settled within the
12 30 days. If proof of loss is not supplied as to the entire
13 claim, the amount supported by proof of loss shall be considered
14 paid on a timely basis if paid within 60 days after receipt of
15 proof of loss by the insurer. Any part of the remainder of the
16 claim that is later supported by proof of loss shall be
17 considered paid on a timely basis if paid within 60 days after
18 receipt of the proof of loss by the insurer. If the proof of
19 loss provided by the claimant contains facts that clearly
20 indicate the need for additional medical information by the
21 insurer in order to determine its liability under a policy of
22 life insurance, the claim shall be considered paid on a timely
23 basis if paid within 60 days after receipt of necessary medical
24 information by the insurer. Payment of a claim shall not be
25 untimely during any period in which the insurer is unable to pay
26 the claim when there is no recipient who is legally able to give
27 a valid release for the payment, or where the insurer is unable

1 to determine who is entitled to receive the payment, if the
2 insurer has promptly notified the claimant of that inability and
3 has offered in good faith to promptly pay the claim upon
4 determination of who is entitled to receive the payment.

5 (4) If benefits are not paid on a timely basis the benefits
6 paid shall bear simple interest from a date 60 days after
7 satisfactory proof of loss was received by the insurer at the
8 rate of 12% per annum, if the claimant is the insured or an
9 individual or entity directly entitled to benefits under the
10 insured's contract of insurance. If the claimant is a third
11 party tort claimant, then the benefits paid shall bear interest
12 from a date 60 days after satisfactory proof of loss was received
13 by the insurer at the rate of 12% per annum if the liability of
14 the insurer for the claim is not reasonably in dispute, the
15 insurer has refused payment in bad faith and the bad faith was
16 determined by a court of law. The interest shall be paid in
17 addition to and at the time of payment of the loss. If the loss
18 exceeds the limits of insurance coverage available, interest
19 shall be payable based upon the limits of insurance coverage
20 rather than the amount of the loss. If payment is offered by the
21 insurer but is rejected by the claimant, and the claimant does
22 not subsequently recover an amount in excess of the amount
23 offered, interest is not due. Interest paid pursuant to this
24 section shall be offset by any award of interest that is payable
25 by the insurer pursuant to the award.

26 (5) If a person contracts to provide benefits and reinsures
27 all or a portion of the risk, the person contracting to provide

1 benefits is liable for interest due to an insured, an individual
2 or entity directly entitled to benefits under its insured's
3 contract of insurance, or a third party tort claimant under this
4 section where a reinsurer fails to pay benefits on a timely
5 basis.

6 (6) If there is any specific inconsistency between this
7 section and sections 3101 to 3177 or the worker's disability
8 compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941,
9 the provisions of this section do not apply. Subsections (7) to
10 (14) do not apply to an entity regulated under the worker's
11 disability compensation act of 1969, 1969 PA 317, MCL 418.101 to
12 418.941. Subsections (7) to (14) do not apply to the processing
13 and paying of medicaid claims that are covered under section 111i
14 of the social welfare act, 1939 PA 280, MCL 400.111i.

15 (7) Subsections (1) to (6) do not apply and subsections (8)
16 to (14) do apply to health plans when paying claims to health
17 professionals, health facilities, home health care providers, and
18 durable medical equipment providers, that are not pharmacies and
19 that do not involve claims arising out of sections 3101 to 3177
20 or the worker's disability compensation act of 1969, 1969 PA 317,
21 MCL 418.101 to 418.941. This section does not affect a health
22 plan's ability to prescribe the terms and conditions of its
23 contracts, other than as provided in this section for timely
24 payment.

25 (8) Each health professional, health facility, home health
26 care provider, and durable medical equipment provider in billing
27 for services rendered and each health plan in processing and

1 paying claims for services rendered shall use the following
2 timely processing and payment procedures:

3 (a) A clean claim shall be paid within 45 days after receipt
4 of the claim by the health plan. A clean claim that is not paid
5 within 45 days shall bear simple interest at a rate of 12% per
6 annum.

7 (b) A health plan shall notify the health professional,
8 health facility, home health care provider, or durable medical
9 equipment provider within 30 days after receipt of the claim by
10 the health plan of all known reasons that prevent the claim from
11 being a clean claim.

12 (c) A health professional, health facility, home health care
13 provider, and durable medical equipment provider have 45 days,
14 and any additional time the health plan permits, after receipt of
15 a notice under subdivision (b) to correct all known defects. The
16 45-day time period in subdivision (a) is tolled from the date of
17 receipt of a notice to a health professional, health facility,
18 home health care provider, or durable medical equipment provider
19 under subdivision (b) to the date of the health plan's receipt of
20 a response from the health professional, health facility, home
21 health care provider, or durable medical equipment provider.

22 (d) If a health professional's, health facility's, home
23 health care provider's, or durable medical equipment provider's
24 response under subdivision (c) makes the claim a clean claim, the
25 health plan shall pay the health professional, health facility,
26 home health care provider, or durable medical equipment provider
27 within the 45-day time period under subdivision (a), excluding

1 any time period tolled under subdivision (c).

2 (e) If a health professional's, health facility's, home
3 health care provider's, or durable medical equipment provider's
4 response under subdivision (c) does not make the claim a clean
5 claim, the health plan shall notify the health professional,
6 health facility, home health care provider, or durable medical
7 equipment provider of an adverse claim determination and of the
8 reasons for the adverse claim determination, **along with the name,**
9 **telephone number, and electronic mail address of the person who**
10 **made the adverse claim determination,** within the 45-day time
11 period under subdivision (a), excluding any time period tolled
12 under subdivision (c).

13 (f) A health professional, health facility, home health care
14 provider, or durable medical equipment provider shall bill a
15 health plan within 1 year after the date of service or the date
16 of discharge from the health facility in order for a claim to be
17 a clean claim.

18 (g) A health professional, health facility, home health care
19 provider, or durable medical equipment provider shall not
20 resubmit the same claim to the health plan unless the time frame
21 in subdivision (a) has passed or as provided in subdivision (c).

22 (9) Notices required under subsection (8) shall be made in
23 writing or electronically.

24 (10) If a health plan determines that 1 or more services
25 listed on a claim are payable, the health plan shall pay for
26 those services and shall not deny the entire claim because 1 or
27 more other services listed on the claim are defective. This

1 subsection does not apply if a health plan and health
2 professional, health facility, home health care provider, or
3 durable medical equipment provider have an overriding contractual
4 reimbursement arrangement.

5 (11) A health plan shall not terminate the affiliation status
6 or the participation of a health professional, health facility,
7 home health care provider, or durable medical equipment provider
8 with a health maintenance organization provider panel or
9 otherwise discriminate against a health professional, health
10 facility, home health care provider, or durable medical equipment
11 provider because the health professional, health facility, home
12 health care provider, or durable medical equipment provider
13 claims that a health plan has violated subsections (7) to (10).

14 (12) A health professional, health facility, home health care
15 provider, durable medical equipment provider, or health plan
16 alleging that a timely processing or payment procedure under
17 subsections (7) to (11) has been violated may file a complaint
18 with the commissioner on a form approved by the commissioner and
19 has a right to a determination of the matter by the commissioner
20 or his or her designee. This subsection does not prohibit a
21 health professional, health facility, home health care provider,
22 durable medical equipment provider, or health plan from seeking
23 court action. A health plan described in subsection (14)(c)(iv)
24 is subject only to the procedures and penalties provided for in
25 subsection (13) and section 402 of the nonprofit health care
26 corporation reform act, 1980 PA 350, MCL 550.1402, for a
27 violation of a timely processing or payment procedure under

1 subsections (7) to (11).

2 (13) In addition to any other penalty provided for by law,
3 the commissioner may impose a civil fine of not more than
4 \$1,000.00 for each violation of subsections (7) to (11) not to
5 exceed \$10,000.00 in the aggregate for multiple violations.

6 (14) As used in subsections (7) to (13):

7 (a) "Clean claim" means a claim that does all of the
8 following:

9 (i) Identifies the health professional, health facility, home
10 health care provider, or durable medical equipment provider that
11 provided service sufficiently to verify, if necessary,
12 affiliation status and includes any identifying numbers.

13 (ii) Sufficiently identifies the patient and health plan
14 subscriber.

15 (iii) Lists the date and place of service.

16 (iv) Is a claim for covered services for an eligible
17 individual.

18 (v) If necessary, substantiates the medical necessity and
19 appropriateness of the service provided.

20 (vi) If prior authorization is required for certain patient
21 services, contains information sufficient to establish that prior
22 authorization was obtained.

23 (vii) Identifies the service rendered using a generally
24 accepted system of procedure or service coding.

25 (viii) Includes additional documentation based upon services
26 rendered as reasonably required by the health plan.

27 (b) "Health facility" means a health facility or agency

1 licensed under article 17 of the public health code, 1978 PA 368,
2 MCL 333.20101 to 333.22260.

3 (c) "Health plan" means all of the following:

4 (i) An insurer providing benefits under an expense-incurred
5 hospital, medical, surgical, vision, or dental policy or
6 certificate, including any policy or certificate that provides
7 coverage for specific diseases or accidents only, or any hospital
8 indemnity, medicare supplement, long-term care, or 1-time limited
9 duration policy or certificate, but not to payments made to an
10 administrative services only or cost-plus arrangement.

11 (ii) A MEWA regulated under chapter 70 that provides
12 hospital, medical, surgical, vision, dental, and sick care
13 benefits.

14 (iii) A health maintenance organization licensed or issued a
15 certificate of authority in this state.

16 (iv) A health care corporation for benefits provided under a
17 certificate issued under the nonprofit health care corporation
18 reform act, 1980 PA 350, MCL 550.1101 to 550.1704, but not to
19 payments made pursuant to an administrative services only or
20 cost-plus arrangement.

21 (d) "Health professional" means a health professional
22 licensed or registered under article 15 of the public health
23 code, 1978 PA 368, MCL 333.16101 to 333.18838.