Senate Fiscal Agency
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BILL ANALYSIS

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Senate Bill 673 (as introduced 11-29-17)
Sponsor: Senator Joe Hune
Committee: Insurance

Date Completed: 11-29-17

CONTENT

The bill would amend the Insurance Code to do the following:

- **Remove an exclusion for nonprofit dental care corporations from certain insurer requirements regarding the timely payment of claims, the payment of interest, processing and payment procedures, and other related matters.**
- **Prohibit a nonprofit dental care corporation from requiring individuals to undergo genetic testing before issuing, renewing, or continuing a policy, or to disclose whether genetic testing had been conducted or genetic results or information, after December 31, 2017.**
- **Prohibit a nonprofit dental care corporation from requiring face-to-face contact between a health care professional and a patient for services provided through telemedicine, after December 31, 2017.**

The bill is tie-barred to Senate Bill 631, which would amend Public Act 125 of 1963 (which provides for the incorporation, supervision, and regulation of nonprofit dental care corporations) to modify the composition of a board of directors of a dental care corporation.

Current Insurer Requirements

Under the Code, a person must pay on a timely basis to its insured, a person directly entitled to benefits under its insured's insurance contract, or a third party tort claimant the benefits provided under the terms of its policy, or pay 12% interest on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims is an unfair trade practice unless the claim is reasonably in dispute.

An insurer must specify in writing the materials that constitute a satisfactory proof of loss within 30 days after receiving a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss is considered paid on a timely basis if paid within 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim is considered paid on a timely basis if paid within 60 days after the insurer's receipt of necessary medical information.

If benefits are not paid on a timely basis, the benefits bear interest as provided in the Code, and the interest must be paid as required by the Code.

If a person contracts to provide benefits and reinsures all or a portion of the risk, the person is liable for interest due to an insured, a person directly entitled to benefits under its insured's insurance contract, or a third party tort claimant if a reinsurer fails to pay benefits on a timely basis.

If there is any specific inconsistency between Chapter 31 (Motor Vehicle Personal and Property Protection) of the Code or the Worker's Disability Compensation Act, the above provisions do not apply. The provisions below do not apply to a person regulated under the Act, or to the processing and payment of Medicaid claims that are covered under the Social Welfare Act.

The above provisions do not apply and the provisions described below do apply to health plans when paying claims to health professionals, health facilities, home health care providers, and durable medical equipment providers, that are not pharmacies and that do not involve claims arising out of Chapter 31 of the Insurance Code or the Worker's Disability Compensation Act.

Each health professional, health facility, home health care provider, and durable medical equipment provider in billing for services rendered and each health plan in processing and paying claims for services rendered must use timely processing and payment procedures outlined under the Code.

If a health plan determines that one or more services listed on a claim are payable, the health plan must pay for those services and may not deny the entire claim because one or more other services listed on the claim are defective.

A health plan may not terminate the affiliation status or the participation of a health professional, health facility, home health care provider, or durable medical equipment provider with a health maintenance organization provider panel or otherwise discriminate against a health professional, health facility, home health care provider, or durable medical equipment provider because that entity claims that a health plan violated the provisions described above.

A health professional, health facility, home health care provider, durable medical equipment provider, or health plan alleging that a timely processing or payment procedure under these provisions has been violated may file a complaint with the Director of the Department of Insurance and Financial Services and has a right to a determination of the matter by the Director or his or her designee.

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

Currently, the above provisions do not apply to a nonprofit dental care corporation operating under Public Act 125 of 1963. The bill would delete this exclusion.

Genetic Testing & Telemedicine

Under the Code, an insurer that delivers, issues for delivery, or renews in the State a health insurance policy may not require an insured or his or her dependent or an asymptomatic applicant for insurance or his or her asymptomatic dependent to do either of the following:

-- Undergo genetic testing before issuing, renewing, or continuing the policy in Michigan.
-- Disclose whether genetic testing has been conducted or the results of genetic testing or genetic information.

A health insurer also may not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the State where the patient is located. Telemedicine services are subject to all terms and conditions of the health insurance policy agreed upon between the policy holder and the insurer, including required copayments, coinsurances, deductibles, and approved amounts.

Regarding the provisions described above, the bill specifies that after December 31, 2017, "insurer" would include a nonprofit dental care corporation operating under Public Act 125 of 1963.

MCL 500.2006 et al. Legislative Analyst: Drew Krogulecki

FISCAL IMPACT

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

Fiscal Analyst: Michael Siracuse

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