HOUSE BILL NO. 5473

February 22, 2024, Introduced by Rep. Schriver and referred to the Committee on Government Operations.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending section 2006 (MCL 500.2006), as amended by 2017 PA 223.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2006. (1) 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, in the alternative, the person must pay to its insured, a person directly entitled to benefits under its insured's insurance contract, or a third party

tort claimant 12% interest, as provided in subsection (4), on claims not paid on a timely basis. Failure to pay claims on a timely basis or to pay interest on claims as provided in subsection (4) is an unfair trade practice unless the claim is reasonably in dispute.

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

(3) An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of 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 proof of loss by the insurer. Any part of the remainder of the claim that is later 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 **insurer's** 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 receipt of **the** necessary medical information by the insurer. Payment of a claim is not untimely during any period in which the insurer is unable to pay the claim ~~if~~ **because** there is no recipient who is legally able to give a valid release for the payment, or ~~if~~ **because** the insurer

is unable to determine who is entitled to receive the payment, if the insurer has promptly notified the claimant of that inability and has offered in good faith to promptly pay the claim on determination of who is entitled to receive the payment.

(4) If benefits are not paid on a timely basis, the benefits paid bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or a person directly entitled to benefits under the insured's insurance contract. If the claimant is a third party tort claimant, the benefits paid bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith, and the bad faith was determined by a court of law. The interest must be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, interest is payable based on the limits of insurance coverage rather than the amount of the loss. If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid as provided in this section must be offset by any award of interest that is payable by the insurer as provided in the award.

(5) If a person contracts to provide benefits and reinsures all or a portion of the risk, the person contracting to provide benefits 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 under this section if a reinsurer fails to pay benefits on a timely basis.

(6) If there is any specific inconsistency between this section and chapter 31 or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, ~~the provisions of~~ this section ~~do~~ **does** not apply. Subsections (7) to (14) do not apply to a person regulated under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. Subsections (7) to (14) do not apply to the processing and paying of Medicaid claims that are covered under section 111i of the social welfare act, 1939 PA 280, MCL 400.111i.

(7) Subsections (1) to (6) do not apply and subsections (8) to (14) 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 or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. This section does not affect a health plan's ability to prescribe the terms and conditions of its contracts, other than as provided in this section for timely payment.

(8) 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 shall use the following timely processing and payment procedures:

(a) 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 a rate of 12% per annum.

(b) A health plan shall notify the health professional, health facility, home health care provider, or durable medical equipment provider within 30 days after receipt of the claim by the health

plan of all known reasons that prevent the claim from being a clean claim.

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

(d) If a health professional's, health facility's, home health care provider's, or durable medical equipment provider's response under subdivision (c) makes the claim a clean claim, the health plan ~~shall~~ **must** pay the health professional, health facility, home health care provider, or durable medical equipment provider within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(e) If a health professional's, health facility's, home health care provider's, or durable medical equipment provider's response under subdivision (c) does not make the claim a clean claim, the health plan ~~shall~~ **must** notify the health professional, health facility, home health care provider, or durable medical equipment provider of an adverse claim determination and of the reasons for the adverse claim determination within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(f) A health professional, health facility, home health care

provider, or durable medical equipment provider must bill a health plan within 1 year after the date of service or the date of discharge from the health facility ~~in order~~ for a claim to be a clean claim.

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

(h) A health plan that is a qualified health plan for the purposes of 45 CFR 156.270 and that, as required in 45 CFR 156.270(d), provides a 3-month grace period to an enrollee who is receiving advance payments of the premium tax credit and who has paid 1 full month's premium may pend claims for services rendered to the enrollee in the second and third months of the grace period. A claim during the second and third months of the grace period is not a clean claim under this section, and interest is not payable under subdivision (a) on that claim if the health plan has complied with the notice requirements of 45 CFR 155.430 and 45 CFR 156.270.

(9) Notices required under subsection (8) must be made in writing or electronically.

(10) If a health plan determines that 1 or more services listed on a claim are payable, the health plan shall pay for those services and shall not deny the entire claim because 1 or more other services listed on the claim are defective. This subsection does not apply if a health plan and health professional, health facility, home health care provider, or durable medical equipment provider have an overriding contractual reimbursement arrangement.

(11) A health plan shall 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 the health professional, health facility, home health care provider, or durable medical equipment provider claims that a health plan has violated subsections (7) to (10).

(12) 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 subsections (7) to (11) has been violated may file a complaint with the director on a form approved by the director and has a right to a determination of the matter by the director or his or her designee. This subsection does not prohibit a health professional, health facility, home health care provider, durable medical equipment provider, or health plan from seeking court action.

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

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

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

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

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

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

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

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

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

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

(*viii*) Includes additional documentation based on services rendered as reasonably required by the health plan.

(b) "Health facility" means a health facility or agency licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to ~~333.22260.~~**333.22121.**

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

(*i*) An insurer providing benefits under a health insurance policy, including a policy, certificate, or contract that provides coverage for specific diseases or accidents only, an expense-incurred vision or dental policy, or a hospital indemnity, Medicare supplement, long-term care, or 1-time limited duration policy or certificate, but not to payments made to an administrative services only or cost-plus arrangement.

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

(d) "Health professional" means an individual licensed, registered, or otherwise authorized to engage in a health profession under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(15) After December 31, 2017, this section applies to a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No.____ or House Bill No. 5477 (request no. 01038'23) of the 102nd Legislature is enacted into law.