SENATE BILL NO. 1088

November 13, 2024, Introduced by Senators BAYER, CAVANAGH, MCMORROW, CHANG, KLINEFELT, POLEHANKI and GEISS and referred to the Committee on Finance, Insurance, and Consumer Protection.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 2006 and 3142 (MCL 500.2006 and 500.3142), section 2006 as amended by 2017 PA 223 and section 3142 as amended by 2019 PA 21.

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 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 -~~**not later than** 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 -~~**not later than** 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 -~~**not later than** 60 days after receipt of 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 there is no recipient who is

legally able to give a valid release for the payment, or if 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~~ **All of the following apply if** benefits are not paid on a timely basis: ~~, the~~

(a) The benefits paid bear simple interest **as provided in subdivision (b)** from a date **beginning** 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 **as provided in subdivision (b)** from a date **beginning** 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.

(b) The interest rate charged under this section must be as follows:

(*i*) 1.5% per month for the first 30 days a payment is late.

(*ii*) 2% per month if the payment is 31 to 90 days late.

(*iii*) 4% per month if the payment is more than 90 days late.

(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 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~~ **not later than 30** days after receipt of the claim by the health plan. A clean claim that is not paid ~~within 45~~ **not later than 30** days **after receipt of the claim by the health plan** bears simple interest at a rate ~~of 12% per annum.~~**specified in subsection (4)(b).**

(b) A health plan shall notify the health professional, health facility, home health care provider, or durable medical equipment provider ~~within~~ **by not later than** 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~~ **30** 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~~ **30-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 pay the health professional, health facility, home health care provider, or durable medical equipment provider ~~within~~ **by not later than** the ~~45-day~~ **30-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 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~~ **by not later than** the ~~45-day~~ **30-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~~ **by not later than** 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~~ **the director's** 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.

(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.

(16) Beginning January 1, 2026, and by not later than January 1 each year thereafter, an insurer shall report all of the following information on its website:

(a) The number of claims as described in subsection (4) paid not later than 60 days after the claim being filed.

(b) The number of claims that were not timely paid under this act.

(c) The amount of interest paid for the untimely payment of claims.

Sec. 3142. (1) Personal protection insurance benefits are payable as loss accrues.

(2) Subject to subsection (3), personal protection insurance benefits are overdue if not paid ~~within~~ **by not later than** 30 days after an insurer receives reasonable proof of the fact and of the

amount of loss sustained. Subject to subsection (3), if reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid ~~within~~ **by not later than** 30 days after the proof is received by the insurer. Subject to subsection (3), any part of the remainder of the claim that is later supported by reasonable proof is overdue if not paid ~~within~~ **by not later than** 30 days after the proof is received by the insurer. For the purpose of calculating the extent to which benefits are overdue, payment must be treated as made on the date a draft or other valid instrument was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

(3) For personal protection insurance benefits under section 3107(1)(a), if a bill for the product, service, accommodations, or training is not provided to the insurer ~~within~~ **by not later than** 90 days after the product, service, accommodations, or training is provided, the insurer has 60 days in addition to 30 days provided under subsection (2) to pay before the benefits are overdue.

(4) An overdue payment bears simple interest ~~at the rate of 12% per annum.~~**as follows:**

(a) 1.5% per month for the first 30 days a payment is late.

(b) 2% per month if the payment is 31 to 90 days late.

(c) 4% per month if the payment is more than 90 days late.