This revised analysis replaces the analysis previously issued on 6-7-00.

House
Legislative
Analysis
Section

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PAYMENT OF HEALTH CARE BENEFITS

Senate Bill 694 (Substitute H-1)
Senate Bill 696 as passed by the Senate
Senate Bill 698 as passed by the Senate
Revised First Analysis (6-7-00)

Sponsor: Sen. Bill Schuette
House Committee: Health Policy
Senate Committee: Health Policy

THE APPARENT PROBLEM:

Reportedly, health professionals and health facilities often wait months for payment from insurers and managed care plans. Some believe that the insurers are engaging in practices designed to slow down the disbursement of payments so that the insurer can hold on to payment funds for investment purposes or to beef up cash flow. Regardless of what factors may be behind such delayed payments, many health providers are experiencing financial difficulties because insurance reimbursements are not being paid on a timely basis. Health care providers maintain that money that should be spent on hiring more medical staff and increasing the quality of care for patients is instead being spent on administrative staff and attempts to collect from insurers. One group practice reportedly had to increase its clerical staff from 6 to 16 and add two billing specialists just to handle late payments and rejections from insurers. The problem is so pervasive that many health care providers report that clean claims (those without informational errors or omissions) submitted for payment to insurers usually take about two to three months for reimbursement, and it is not uncommon to have some exceed 90 days and longer, with some health care providers reporting payments that took 18 months and more.

The problem is not unique to Michigan. In fact, in recent years, 38 states have enacted legislation to deal with delayed payments from insurers, and state regulators are cracking down on offenders. According to an article in the American Medical News (April 17, 2000), in response to complaints that health maintenance organizations (HMOs) weren't following Georgia law requiring timely payments, the insurance commissioner began to require that HMOs submit quarterly claims data. The quarterly review plan has already led to one large HMO being fined over a quarter of a million dollars for late claims payments. Many within the health care industry believe that Michigan should also adopt laws to establish a timely claims payment procedure.

THE CONTENT OF THE BILLS:

The bills would require the commissioner of the Office of Financial and Insurance Services to establish a timely claims processing and payment procedure to be used by health professionals and facilities, and by health insurers, health maintenance organizations, and Blue Cross and Blue Shield of Michigan. The bills would take effect on January 1, 2001 and would apply to all health care claims submitted for payment on and after that date.

Currently, Section 2006 of the Insurance Code requires insurers to pay benefits under a contract of insurance, on a timely basis. An insurer must specify in writing the materials that constitute a satisfactory proof of loss within 30 days after receiving a claim. A claim is considered to be paid on a timely basis if paid within 60 days after the insurer receives proof of loss, unless there is no recipient who can legally give a valid release for the payment, or the insurer is unable to determine who is entitled to receive payment. The insured is entitled to interest at 12 percent per year for claims not paid on a timely basis. Failure to pay claims on a timely basis, or to pay interest as required, is an unfair trade practice unless a claim is reasonably in dispute. Senate Bill 694 states that these provisions would not apply to health plans when paying claims to health professionals and facilities that did not involve claims arising out of a section pertaining to motor vehicle protection or the Worker's Disability Compensation Act, and would instead institute new requirements for health plans (see below).

Specifically, the bills would do the following:

Senate Bill 694 would amend the Insurance Code (MCL 500.2006) to require the commissioner of the Office of Financial and Insurance Services (OFIS) to establish a timely claims processing and payment procedure to be used by health professionals and facilities in billing for, and health plans in processing and paying claims for, services rendered. "Health plan" would mean an insurer providing benefits under an expense-incurred hospital, medical, surgical, vision, or dental policy or certificate; a MEWA regulated under Chapter 70 of the code that provides hospital, medical, surgical, vision, dental, and sick care benefits; an HMO licensed or issued a certificate of authority in this state; and Blue Cross Blue Shield of Michigan for benefits provided under a certificate issued under the Nonprofit Health Care Corporation Reform Act. The bill would not apply to an entity regulated under the Worker's Disability Compensation Act. The provisions would apply to health plans when paying claims to health professionals and facilities that did not involve claims arising out of a section pertaining to motor vehicle protection or the Worker's Disability Compensation Act.

The commissioner would have to consult with the Department of Community Health, health professionals and facilities, and health plans in establishing the timely payment procedure. The timely claims payment procedure would have to provide that "clean claim" would mean a claim that, at a minimum, would do the following:

• Identified the health professional or health facility that provided treatment or service, including a matching identifying number.

• Identified the patient and health plan subscriber.

• Listed the date and place of service.

• Was for covered services for an eligible individual.

• If necessary, substantiated the medical necessity and appropriateness of the care or service provided.

• If prior authorization were required for certain patient care or services, included any authorization number.

• Included additional documentation based upon services rendered as reasonably required by the health plan.

The timely claims processing and payment procedure would also have to provide for all the following:

• A universal system of coding to be used for all claims submitted to health plans. Any universal coding system developed by the federal government would replace one developed under the bill.

• That a claim would have to be transmitted electronically or as otherwise specified by the commissioner. A health plan would have to be able to receive claims transmitted electronically.

• The number of days after a service was provided within which a health professional and facility must bill a health plan for the claim.

• That a clean claim be paid within 45 days after the health plan received it. A clean claim not paid within the time frame would bear simple interest at the rate of 12 percent per year. For a pharmaceutical clean claim, the clean claim would have to be paid within the industry standard time frame for paying the claim as of the effective date of the bill or within 45 days of the health plan receiving the claim, whichever was sooner.

• That a health plan would have to state in writing to the health professional or facility any defect in the claim within 30 days after receiving it.

• That a health professional and health facility would have 30 days after receiving a notice that a claim was defective within which to correct the defect. The health plan would have to pay the claim within 30 days after the defect was corrected.

• That a health plan would have to notify the health professional or facility of the defect, if a claim were returned from a health professional or facility within the allowable 30-day period and the claim remained defective for the original reason or a new reason.

• That a health plan would have to report, to the commissioner, the number of claims that had not been paid within the prescribed time limits. Beginning six months following the bill's effective date, the quarterly reports would be due on January 1, April 1, July 1, and October 1 of each year.

• Penalties to be applied to health professionals, health facilities, and health plans for failing to adhere to the timely claims processing and payment procedure.

• A system for notifying the licensing entity if a penalty was incurred.

• That the commissioner would hear a disputed penalty as a contested case under the Administrative Procedures Act.

• That an external review procedure for adverse determinations of payment be established. The costs for the external review would be assessed as determined by the commissioner.

Further, if a health plan determined that one or more covered services listed on a claim were payable, the health plan would have to pay for those services and not deny the entire claim because other covered services listed on the claim were defective. This provision would not apply if the health plan and health professional or health facility had an overriding contractual reimbursement arrangement.

By October 1, 2001, the commissioner would have to report to the Senate and House Appropriations subcommittees on health and insurance issues on the timely claims processing and payment procedures established under the bill.

Senate Bill 696 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1403), which regulates Blue Cross and Blue Shield of Michigan (BCBSM), to provide that the provisions of Senate Bill 694 would apply to BCBSM, and to delete a provision that interest on a payment claim accrues at a rate of 12 percent per year, if BCBSM did not pay the claim within 60 days after receiving a claim form. The bill is tie-barred to Senate Bill 694.

Senate Bill 698 would amend the Public Health Code (MCL 333.21095) to provide that the provisions of Senate Bill 694 would apply to health maintenance organizations (HMOs). The bill is tie-barred to Senate Bill 694. (Note: Two bills, House Bill 5575 (which has passed the House and is waiting Senate committee action) and Senate Bill 1209 (which is pending on the House calendar), would repeal Part 210 of the Public Health Code (MCL 333.21001 to 333.21098) which currently regulates HMOs, and place statutory regulation of HMOs within the Insurance Code.)

HOUSE COMMITTEE ACTION:

The House Health Policy Committee amended Senate Bill 694 to:

• Update references to the "commissioner" to reflect the newly created position of commissioner of the Office of Financial and Insurance Services.

• Require that covered services would be for eligible individuals.

• Specify that for a pharmaceutical clean claim, the clean claim would have to be paid within the industry standard time frame for paying the claim as of the effective date of the bill or within 45 days of the health plan receiving the claim, whichever was sooner.

• Require that an external review procedure for adverse determinations of payment be established. The costs for the external review would be assessed as determined by the commissioner.

• Specify that "health plan" includes a health care corporation for benefits provided under a certificate issued under the Nonprofit Health Care Corporation Reform Act.

BACKGROUND INFORMATION

A similar bill, Senate Bill 938, that pertains to timely payments for Medicaid services, has been reported from the House Appropriations Committee.

FISCAL IMPLICATIONS:

According to an analysis by the Office of Financial and Insurance Services, the bills as passed by the Senate would result in an indeterminate increase in state costs as the Insurance Division would require additional staff to keep the claims payment dispute process timely. (5-30-00)

ARGUMENTS:

For:

Health care providers across the state are complaining about the increasingly difficult task of receiving payments for claims in a timely manner. Some offices have been forced to increase their administrative staff, even hire billing specialists, to track unpaid claims and battle with health insurers in order to get paid for covered services. This situation is problematic for several reasons. Doctors must spend an increasing

amount of time with their billing staff to answer questions in regards to rejected claims, instead of spending that time providing care to patients. Revenue that could be spent on newer medical equipment, hiring additional medical personnel, and so forth, must instead be spent on hiring additional administrative staff to deal with the amount of unpaid claims. Further, health care providers can be in the situation where a substantial amount of operating capital can be tied up in pending claims, thus placing their practices in a financially precarious place. Mounting debt from backlogs in reimbursements from services already rendered threaten many medical practices and health facilities. Reportedly, one doctor had to charge $20,000 to his personal credit card account in order to make his payroll and pay other office expenses.

Part of the problem lies in the lack of a consistent definition of what constitutes a clean claim. Providers often feel that claims are rejected as defective when that is not the case, necessitating rebilling and resulting in another long wait to receive payment. Further, there is little recourse for providers or consumers if a health plan or insurer is consistently slow in responding to paying claims. Senate Bill 694 and its companion bills would help remedy the situation by requiring the commissioner of the Office of Financial and Insurance Services (OFIS) to create a timely claims processing and payment procedure. The bills would focus on those claims that are not disputed. Under Senate Bill 694, the term "clean claim" would be defined, and penalties would be levied on providers or insurers who do not comply with the provisions for timely submission and payment of claims. A universal coding system would have to be adopted, and electronic transmission would have to be utilized. These provisions should greatly reduce the number of claims declared to be defective and speed up the claims process. Those plans, or providers, who consistently were found to be in noncompliance with the timely claims process could face fines. In short, as a whole, the bill package creates a mechanism by which insurance claims should be processed more quickly and consistently. In addition to helping consumers and providers, a major benefit of quicker claims payment and fewer disputed claims could be that both providers and insurers see a cost savings that could be passed on to consumers.

Against:

This legislation needs to be slowed down and reviewed carefully. As written, the scope of Senate Bill 694 remains unclear to many. If the aim of the legislation is to make sure that more claims are paid in a timely manner, the language may need to be made more specific about which plans are covered. The bill defines "health plans" as those plans that currently come under state regulation. This appears to mean that the bill would not apply to administrative services only contracts (ASO contracts). ASO services are, in general, administrative services such as claims processing provided for a self-insured health benefit plan. Such self-insured plans, which cover a great many people in Michigan, are generally preempted from state regulation under federal ERISA laws (the Employee Retirement Income Security Act that regulates employee pension and benefit plans). Further, as the bill specifies that it applies to health plans "when paying claims to health professionals and facilities", it is likely that it would not apply to those health plans that only reimburse the individual who purchases a health plan out-of-pocket or when an insured goes to a physician or facility that does not participate in his or her health plan and so receives reimbursement directly from the health plan.

Against:

There are several remaining concerns with Senate Bill 694 that have been raised by those in the health and insurance industries, including the following:

• The sheer scope of the number of financial transactions that could be involved could prove daunting. In 1995, approximately $30 billion in medical claims were processed. If even a fraction of those claims were appealed to the commissioner for resolution, it could overwhelm the Division of Insurance's capabilities to monitor and implement the bill's provisions.

• Though many other states have enacted similar legislation, the number of lawsuits and class action suits being filed in many states are evidence that such legislation is difficult to implement and enforce. A better approach would be the creation of an effective mechanism for quick and affordable mediation (appeals under the Administrative Procedures Act can be laborious and time consuming) or to let the commissioner more closely monitor disputed claims and levy penalties under a package of bills reforming HMO and insurance laws that is currently before the legislature.

• Problems remain with the definition of "clean claim", as the substantiation of "the medical necessity and appropriateness of the care or service" is also included in current law that establishes time lines for internal grievance procedures and is also criteria for consumers to seek an external review of disputed claims under both current and pending legislation. The bill also calls

for the establishment of an external review procedure for adverse determinations of payment. It is not clear if this is in addition to the external review procedure created under House Bill 5576, which is pending before the legislature. If so, a conflict could be created between consumers appealing to the commissioner and a health care provider also appealing to the commissioner for the same claims, either simultaneously or consecutively. Further, as insurers could also be asked to bear the brunt of the external review process under House Bill 5576, to also levy an assessment to cover the costs of an external review under this bill would be excessive.

• It is not clear if the time lines in the bill can be "tolled" if an insurer is having difficulty obtaining the necessary documentation for a claim within the prescribed time frame, or if the clock would keep ticking, so to speak. Further, some claims, such as those involving hospitalization, may have records held by more than one provider or facility. The bill does not clearly specify what would happen in regards to penalties or time lines when one party is late releasing its share of the records for a particular claim.

• Providers already sign contracts with health plans that spell out how claims are to be handled. A provider contract would be a more efficient vehicle in which to correct inequities. If a plan does not pay claims quickly or resolve disputes fairly, the plan may lose so many doctors on its panel that it could not continue to meet statutory levels of provider service for a particular geographic area and would be forced out of business.

• The bill would represent yet another legislative attempt to have a state agency superimpose itself on a contract between two private parties.

• Pharmacies would be under a different time line than other providers. This could be very problematic for health plans and insurers, as some insurers currently average under two days to reimburse a pharmacy. Since the bill would set the current industry standard as the time line, would that make a payment that took three days a late payment and therefore subject to penalties?

• The bills could prove very costly to implement. Other legislation currently pending before the legislature would also increase the duties of the commissioner and his or her staff and necessitate the hiring of additional staff. Enactment of this package would further add to the duties of the commissioner. Some estimates put the needed staff additions at 20 full time employees just for Senate Bills 694, 696, and 698. It would be hard to pass this entire cost on to providers or insurers. Sooner or later, it is going to be the consumer who bears the brunt in increased medical and health insurance costs.

POSITIONS:

The Michigan State Medical Society supports the bills. (6-6-00)

The Michigan Osteopathic Association supports the bills. (6-6-00)

The Michigan Medical Group Management Association supports the bills. (6-6-00)

The Office of Financial and Insurance Services opposes the bills. (6-6-00)

The Michigan Chiropractic Society opposes the bills. (6-6-00)

Blue Cross and Blue Shield of Michigan opposes the House committee version of the bills. (6-6-00)

The Michigan Association of Health Plans indicated opposition to the bills. (6-6-00)

The Health Insurance Association of America (HIAA) indicated opposition to the bills. (6-6-00)

The Economic Alliance has many concerns with the bills as written and requests that time be taken to consider the impact of the legislation. (6-6-00)

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.