

**HOUSE SUBSTITUTE FOR  
SENATE BILL NO. 588**

A bill to amend 1956 PA 218, entitled  
"The insurance code of 1956,"  
by amending section 2006 (MCL 500.2006), as amended by 2002  
PA 316.

**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

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, ~~and~~ health facilities, **home health care**  
18 **providers, and durable medical equipment providers**, that are not  
19 pharmacies and that do not involve claims arising out of sections  
20 3101 to 3177 or the worker's disability compensation act of 1969,  
21 1969 PA 317, MCL 418.101 to 418.941. **This section does not**  
22 **affect a health plan's ability to prescribe the terms and**  
23 **conditions of its contracts, other than as provided in this**  
24 **section for timely payment.**

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

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

23 (d) If a health professional's, ~~or~~ health facility's, **home**  
24 **health care provider's, or durable medical equipment provider's**  
25 response under subdivision (c) makes the claim a clean claim, the  
26 health plan shall pay the health professional, ~~or~~ health  
27 facility, **home health care provider, or durable medical equipment**

1 **provider** within the 45-day time period under subdivision (a),  
2 excluding any time period tolled under subdivision (c).

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

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

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

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

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

1 professional, ~~or~~ health facility, **home health care provider, or**  
2 **durable medical equipment provider** have an overriding contractual  
3 reimbursement arrangement.

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

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

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

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

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

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

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

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

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

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

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

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

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

26           (b) "Health facility" means a health facility or agency  
27 licensed under article 17 of the public health code, 1978 PA 368,



1 MCL 333.20101 to 333.22260.

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

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

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

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

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

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

23 Enacting section 1. This amendatory act takes effect 6  
24 months after the date it is enacted into law and applies to all  
25 health care claims with dates of service on and after the  
26 effective date of this amendatory act.