

**HOUSE SUBSTITUTE FOR  
SENATE BILL NO. 673**

A bill to amend 1956 PA 218, entitled  
"The insurance code of 1956,"  
by amending sections 2006, 3407b, and 3476 (MCL 500.2006,  
500.3407b, and 500.3476), as amended by 2016 PA 276.

**THE PEOPLE OF THE STATE OF MICHIGAN ENACT:**

1       Sec. 2006. (1) A person must pay on a timely basis to its  
2 insured, a person directly entitled to benefits under its insured's  
3 insurance contract, or a third party tort claimant the benefits  
4 provided under the terms of its policy, or, in the alternative, the  
5 person must pay to its insured, a person directly entitled to  
6 benefits under its insured's insurance contract, or a third party  
7 tort claimant 12% interest, as provided in subsection (4), on  
8 claims not paid on a timely basis. Failure to pay claims on a  
9 timely basis or to pay interest on claims as provided in subsection

1 (4) is an unfair trade practice unless the claim is reasonably in  
2 dispute.

3 (2) A person shall not be found to have committed an unfair  
4 trade practice under this section if the person is found liable for  
5 a claim pursuant to a judgment rendered by a court of law, and the  
6 person pays to its insured, the person directly entitled to  
7 benefits under its insured's insurance contract, or the third party  
8 tort claimant interest as provided in subsection (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 30  
12 days. If proof of loss is not supplied as to the entire claim, the  
13 amount supported by proof of loss is considered paid on a timely  
14 basis if paid within 60 days after receipt of proof of loss by the  
15 insurer. Any part of the remainder of the claim that is later  
16 supported by proof of loss is considered paid on a timely basis if  
17 paid within 60 days after receipt of the proof of loss by the  
18 insurer. If the proof of loss provided by the claimant contains  
19 facts that clearly indicate the need for additional medical  
20 information by the insurer in order to determine its liability  
21 under a policy of life insurance, the claim is considered paid on a  
22 timely basis if paid within 60 days after receipt of necessary  
23 medical information by the insurer. Payment of a claim is not  
24 untimely during any period in which the insurer is unable to pay  
25 the claim if there is no recipient who is legally able to give a  
26 valid release for the payment, or if the insurer is unable to  
27 determine who is entitled to receive the payment, if the insurer

1 has promptly notified the claimant of that inability and has  
2 offered in good faith to promptly pay the claim ~~upon~~**ON**  
3 determination of who is entitled to receive the payment.

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

23 (5) If a person contracts to provide benefits and reinsures  
24 all or a portion of the risk, the person contracting to provide  
25 benefits is liable for interest due to an insured, a person  
26 directly entitled to benefits under its insured's insurance  
27 contract, or a third party tort claimant under this section if a

1 reinsurer fails to pay benefits on a timely basis.

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

11 (7) Subsections (1) to (6) do not apply and subsections (8) to  
12 (14) do apply to health plans when paying claims to health  
13 professionals, health facilities, home health care providers, and  
14 durable medical equipment providers, that are not pharmacies and  
15 that do not involve claims arising out of chapter 31 or the  
16 worker's disability compensation act of 1969, 1969 PA 317, MCL  
17 418.101 to 418.941. This section does not affect a health plan's  
18 ability to prescribe the terms and conditions of its contracts,  
19 other than as provided in this section for timely payment.

20 (8) Each health professional, health facility, home health  
21 care provider, and durable medical equipment provider in billing  
22 for services rendered and each health plan in processing and paying  
23 claims for services rendered shall use the following timely  
24 processing and payment procedures:

25 (a) A clean claim must be paid within 45 days after receipt of  
26 the claim by the health plan. A clean claim that is not paid within  
27 45 days bears simple interest at a rate of 12% per annum.

1 (b) A health plan shall notify the health professional, health  
2 facility, home health care provider, or durable medical equipment  
3 provider within 30 days after receipt of the claim by the health  
4 plan of all known reasons that prevent the claim from being a clean  
5 claim.

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

16 (d) If a health professional's, health facility's, home health  
17 care provider's, or durable medical equipment provider's response  
18 under subdivision (c) makes the claim a clean claim, the health  
19 plan shall pay the health professional, health facility, home  
20 health care provider, or durable medical equipment provider within  
21 the 45-day time period under subdivision (a), excluding any time  
22 period tolled under subdivision (c).

23 (e) If a health professional's, health facility's, home health  
24 care provider's, or durable medical equipment provider's response  
25 under subdivision (c) does not make the claim a clean claim, the  
26 health plan shall notify the health professional, health facility,  
27 home health care provider, or durable medical equipment provider of

1 an adverse claim determination and of the reasons for the adverse  
2 claim determination within the 45-day time period under subdivision  
3 (a), excluding any time period tolled under subdivision (c).

4 (f) A health professional, health facility, home health care  
5 provider, or durable medical equipment provider must bill a health  
6 plan within 1 year after the date of service or the date of  
7 discharge from the health facility in order for a claim to be a  
8 clean claim.

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

13 (h) A health plan that is a qualified health plan for the  
14 purposes of 45 CFR 156.270 and that, as required in 45 CFR  
15 156.270(d), provides a 3-month grace period to an enrollee who is  
16 receiving advance payments of the premium tax credit and who has  
17 paid 1 full month's premium may pend claims for services rendered  
18 to the enrollee in the second and third months of the grace period.  
19 A claim during the second and third months of the grace period is  
20 not a clean claim under this section, and interest is not payable  
21 under subdivision (a) on that claim if the health plan has complied  
22 with the notice requirements of 45 CFR 155.430 and 45 CFR 156.270.

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

25 (10) If a health plan determines that 1 or more services  
26 listed on a claim are payable, the health plan shall pay for those  
27 services and shall not deny the entire claim because 1 or more

1 other services listed on the claim are defective. This subsection  
2 does not apply if a health plan and health professional, health  
3 facility, home health care provider, or durable medical equipment  
4 provider have an overriding contractual reimbursement arrangement.

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

14 (12) A health professional, health facility, home health care  
15 provider, durable medical equipment provider, or health plan  
16 alleging that a timely processing or payment procedure under  
17 subsections (7) to (11) has been violated may file a complaint with  
18 the director on a form approved by the director and has a right to  
19 a determination of the matter by the director or his or her  
20 designee. This subsection does not prohibit a health professional,  
21 health facility, home health care provider, durable medical  
22 equipment provider, or health plan from seeking court action.

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (i) An insurer providing benefits under a health insurance  
26 policy, including a policy, certificate, or contract that provides  
27 coverage for specific diseases or accidents only, an expense-



1 incurred vision or dental policy, or a hospital indemnity, Medicare  
2 supplement, long-term care, or 1-time limited duration policy or  
3 certificate, but not to payments made to an administrative services  
4 only or cost-plus arrangement.

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

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

11 (15) ~~This~~ **AFTER DECEMBER 31, 2017, THIS** section ~~does not apply~~  
12 **APPLIES** to a nonprofit dental care corporation operating under 1963  
13 PA 125, MCL 550.351 to 550.373.

14 Sec. 3407b. (1) An insurer that delivers, issues for delivery,  
15 or renews in this state a health insurance policy shall not require  
16 an insured or his or her dependent or an asymptomatic applicant for  
17 insurance or his or her asymptomatic dependent to do either of the  
18 following:

19 (a) Undergo genetic testing before issuing, renewing, or  
20 continuing the policy in this state.

21 (b) Disclose whether genetic testing has been conducted or the  
22 results of genetic testing or genetic information.

23 (2) As used in this section:

24 (a) "Clinical purposes" includes all of the following:

25 (i) Predicting risk of diseases.

26 (ii) Identifying carriers for single-gene disorders.

27 (iii) Establishing prenatal and clinical diagnosis or

1 prognosis.

2 (iv) Prenatal, newborn, and other carrier screening, as well  
3 as testing in high-risk families.

4 (v) Testing for metabolites if undertaken with high  
5 probability that an excess or deficiency of the metabolite  
6 indicates or suggests the presence of heritable mutations in single  
7 genes.

8 (vi) Other testing if the intended purpose is diagnosis of a  
9 presymptomatic genetic condition.

10 (b) "Genetic information" means information about a gene, gene  
11 product, or inherited characteristic derived from a genetic test.

12 (c) "Genetic test" means the analysis of human DNA, RNA,  
13 chromosomes, and those proteins and metabolites used to detect  
14 heritable or somatic disease-related genotypes or karyotypes for  
15 clinical purposes. A genetic test must be generally accepted in the  
16 scientific and medical communities as being specifically  
17 determinative for the presence, absence, or mutation of a gene or  
18 chromosome to qualify under this definition. Genetic test does not  
19 include a routine physical examination or a routine analysis,  
20 including, but not limited to, a chemical analysis, of body fluids,  
21 unless conducted specifically to determine the presence, absence,  
22 or mutation of a gene or chromosome.

23 **(D) AFTER DECEMBER 31, 2017, "INSURER" INCLUDES A NONPROFIT**  
24 **DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO**  
25 **550.373.**

26 Sec. 3476. (1) An insurer that delivers, issues for delivery,  
27 or renews in this state a health insurance policy shall not require

1 face-to-face contact between a health care professional and a  
2 patient for services appropriately provided through telemedicine,  
3 as determined by the insurer. Telemedicine services must be  
4 provided by a health care professional who is licensed, registered,  
5 or otherwise authorized to engage in his or her health care  
6 profession in the state where the patient is located. Telemedicine  
7 services are subject to all terms and conditions of the health  
8 insurance policy agreed upon between the policy holder and the  
9 insurer, including, but not limited to, required copayments,  
10 coinsurances, deductibles, and approved amounts.

11 (2) As used in this section: ~~,"telemedicine"~~

12 **(A) AFTER DECEMBER 31, 2017, "INSURER" INCLUDES A NONPROFIT**  
13 **DENTAL CARE CORPORATION OPERATING UNDER 1963 PA 125, MCL 550.351 TO**  
14 **550.373.**

15 **(B) "TELEMEDICINE"** means the use of an electronic media to  
16 link patients with health care professionals in different  
17 locations. To be considered telemedicine under this section, the  
18 health care professional must be able to examine the patient via a  
19 real-time, interactive audio or video, or both, telecommunications  
20 system and the patient must be able to interact with the off-site  
21 health care professional at the time the services are provided.

22 Enacting section 1. This amendatory act does not take effect  
23 unless Senate Bill No. 631 of the 99th Legislature is enacted into  
24 law.