HOUSE OF REPRESENTATIVES
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

# H.B. NO. 1555

# A BILL FOR AN ACT

RELATING TO INSURANCE.

**BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:**

SECTION 1. Section 431:13-108, Hawaii Revised Statutes, is amended to read as follows:

"**§431:13-108 Reimbursement for accident and health or sickness insurance [~~benefits.~~] benefit claims; clean claim payments; health plan recoupment.** (a) [~~This section applies to accident and health or sickness insurers issuing comprehensive medical plans under part I of article 10A of chapter 431, mutual benefit societies under article 1 of chapter 432, dental service corporations under chapter 423, and health maintenance organizations under chapter 432D.~~] An entity shall pay an insured and health care provider:

(1) Clean claims on a timely basis; and

(2) Twelve per cent interest on clean claims not paid on a timely basis.

(b) Unless shorter payment timeframes are otherwise specified in a contract, an entity shall reimburse a clean claim [~~that is not contested or denied~~] not more than thirty calendar

days after receiving the claim filed in writing, or fifteen calendar days after receiving the claim filed electronically, as appropriate.

(c) If a claim is contested or denied or requires more time for review by an entity, the entity shall notify the health care provider in writing or electronically not more than fifteen calendar days after receiving a claim filed in writing, or not more than seven calendar days after receiving a claim filed electronically, as appropriate. The notice shall identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may request additional information; provided that a notice shall not be required if the entity provides a reimbursement report containing the information, at least monthly, to the health care provider.

(d) Every entity shall implement and make accessible to health care providers a system that provides verification of enrollee eligibility under plans offered by the entity.

(e) If information received pursuant to a request for additional information is satisfactory to warrant paying the claim, the claim shall be paid not more than thirty calendar days after receiving the additional information in writing, or

not more than fifteen calendar days after receiving the additional information filed electronically, as appropriate.

(f) Payment of a claim under this section shall be effective upon the date of the postmark of the mailing of the payment, or the date of the electronic transfer of the payment, as applicable.

(g) Notwithstanding section 478-2 to the contrary, interest shall be allowed at a rate of [~~fifteen~~] twelve per cent a year for money owed by an entity on payment of a claim exceeding the applicable time limitations under this section, as follows:

(1) For [~~an uncontested~~] a clean claim:

(A) Filed in writing, interest from the first calendar day after the thirty-day period in subsection (b); or

(B) Filed electronically, interest from the first calendar day after the fifteen-day period in subsection (b);

(2) For a contested claim filed in writing:

(A) For which notice was provided under subsection (c), interest from the first calendar day thirty

days after the date the additional information is received; or

(B) For which notice was not provided within the time specified under subsection (c), interest from the first calendar day after the claim is received; or

(3) For a contested claim filed electronically:

(A) For which notice was provided under subsection (c), interest from the first calendar day fifteen days after the additional information is received; or

(B) For which notice was not provided within the time specified under subsection (c), interest from the first calendar day after the claim is received.

The commissioner may suspend the accrual of interest if the commissioner determines that the entity's failure to pay a claim within the applicable time limitations was the result of a major disaster or of an unanticipated major computer system failure.

(h) [~~Any interest that accrues in a sum of at least $2 on a delayed clean claim in this section shall be automatically added by the entity to the amount of the unpaid claim due the~~

~~provider.~~] The commissioner shall not suspend the accrual of interest for the payment of clean claims related to the non-implementation or inoperability of ICD-10 (International Classification of Diseases, Revision 10) for processing claims.

(i) Prior to initiating any recoupment or offset demand efforts, an entity shall send a written notice to a health care provider at least thirty calendar days prior to engaging in the recoupment or offset efforts. The following information shall be prominently displayed on the written notice:

(1) The patient's name;

(2) The date health care services were provided;

(3) The payment amount received by the health care provider;

(4) The reason for the recoupment or offset; and

(5) The telephone number or mailing address through which a health care provider may initiate an appeal along with the deadline for initiating an appeal. Any appeal of a recoupment or offset shall be made by a health care provider within sixty days after the receipt of the written notice.

(j) An entity shall not initiate recoupment or offset efforts more than eighteen months after the initial claim payment was received by the health care provider or health care entity; provided that this time limit shall not apply to the initiation of recoupment or offset efforts: to claims for self-insured employer groups; for services rendered to individuals associated with a health care entity through a national participating provider network; or for claims for medicaid, medicare, medigap, or other federally financed plan; provided that this section shall not be construed to prevent entities from resolving claims that involve coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability beyond the eighteen month time limit; provided further that in cases of fraud or material misrepresentation, an entity shall not initiate recoupment or offset efforts more than seventy-two months after the initial claim payment was received by the health care provider or health care entity.

(k) In addition to any other penalty provided for by law, the commissioner may impose a civil fine of not more than $1,000 for each violation of this section not to exceed $10,000 in the

aggregate for multiple violations. In determining the penalties [~~under section 431:13-201~~] for a violation of this section, the commissioner shall consider:

(1) The appropriateness of the penalty in relation to the financial resources and good faith of the entity;

(2) The gravity of the violation;

(3) The history of the entity for previous similar violations;

(4) The economic benefit to be derived by the entity and the economic impact upon the health care facility or health care provider resulting from the violation; and

(5) Any other relevant factors bearing upon the violation.

(l) As used in this section:

"Acute care hospital" means a hospital that provides inpatient medical care and other related services for surgery or acute medical conditions or injuries (usually for a short term illness or condition).

"Claim" means any claim, bill, or request for payment for all or any portion of health care services provided by a health care provider of services submitted by an individual or pursuant to a contract or agreement with an entity, using the entity's

standard claim form with all required fields completed with correct and complete information.

"Clean claim" means a claim [~~in~~]:

(1) In which the information in the possession of an entity adequately indicates that:

[~~(1)~~] (A) The claim is for a covered health care service provided by an eligible health care provider to a covered person under the contract;

[~~(2)~~] (B) The claim has no material defect or impropriety;

[~~(3)~~] (C) There is no dispute regarding the amount claimed; and

[~~(4)~~] (D) The payer has no reason to believe that the claim was submitted fraudulently[~~.~~];

(2) That identifies the health care provider sufficiently to verify, if necessary, affiliation status and includes any identifying numbers;

(3) That sufficiently identifies the patient and the health care provider;

(4) That lists the date and place of service;

(5) That is a claim for covered services, including any medicaid claim or Med-QUEST claim, for a health care provider;

(6) That, if necessary, substantiates the medical necessity and appropriateness of the service provided;

(7) That, if prior authorization is required for certain services, contains information sufficient to establish that prior authorization was obtained;

(8) That identifies the service rendered using a generally accepted system of procedure or service coding; and

(9) That includes additional documentation based upon services rendered as reasonably required by the entity.

The term does not include:

(1) Claims for payment of expenses incurred during a period of time when premiums were delinquent;

(2) Claims that are submitted fraudulently or that are based upon material misrepresentations;

(3) Claims for self-insured employer groups; claims for services rendered to individuals associated with a health care entity through a national participating

provider network; or claims for [~~medicaid,~~] medicare, medigap, or other federally financed plan[~~.~~], excluding medicaid; and

(4) Claims that require a coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability.

"Contest", "contesting", or "contested" means the circumstances under which an entity was not provided with, or did not have reasonable access to, sufficient information needed to determine payment liability or basis for payment of the claim.

"Deny", "denying", or "denied" means the assertion by an entity that it has no liability to pay a claim based upon eligibility of the patient, coverage of a service, medical necessity of a service, liability of another payer, or other grounds.

"Entity" means accident and health or sickness insurance providers under part I of article 10A of chapter 431, mutual benefit societies under article 1 of chapter 432, dental service corporations under chapter 423, and health maintenance organizations under chapter 432D.

"Fraud" shall have the same meaning as in section 431:2-403.

"Health care facility" shall have the same meaning as in section 323D-2; provided that health care facility shall not include an acute care hospital.

"Health care provider" means a Hawaii health care facility, physician, nurse, or any other provider of health care services covered by an entity[~~.~~], including care homes and durable medical equipment providers."

SECTION 2. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 3. If any part of this Act is found to be in conflict with federal requirements that are a prescribed condition for the allocation of federal funds to the State, the conflicting part of this Act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this Act in its application to the agencies concerned.

SECTION 4. This Act shall take effect upon its approval.

INTRODUCED BY: John M. Mizuno

JAN 13 2016

# H.B. NO. 1555

**Report Title:**
Clean Claims; Prompt Payment of Health Insurance Benefits

**Description:**
Requires the prompt payment of accident and health or sickness insurance benefits to health care providers within 30 days of receipt of a clean claim. Establishes penalties for nonpayment of clean claims in a specified time period.

*The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.*