HOUSE OF REPRESENTATIVES
THIRTY-SECOND LEGISLATURE, 2023
STATE OF HAWAII

H.B. NO. 1446

A BILL FOR AN ACT

RELATING TO INSURANCE.

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

1 SECTION 1. The legislature finds that section 431:13-108,
2 Hawaii Revised Statutes, also known as the clean claims statute,
3 requires health plans to pay health care providers on a timely
4 basis when uncontested claims are submitted. Under this law,
5 insurers are required to reimburse providers for clean claims
6 payments within thirty days for clean claims submitted in
7 writing, and within fifteen days for clean claims submitted
8 electronically. For contested claims, health insurers may
9 initiate a demand for recoupment. Insurance recoupment occurs
10 when a health insurer pays benefits to health care providers and
11 later seeks reimbursement for the benefits.
12 The legislature further finds that the clean claims statute
13 prohibits health insurers from initiating recoupment efforts
14 more than eighteen months after the initial claim payment was
15 received by a health care provider. However, claims that
16 involve coordination of benefits, subrogation, or preexisting
17 condition investigations, or that involve third-party liability

1 are not subject to a time frame in which a health insurer can
2 initiate recoupment efforts from a health care provider. Any
3 associated delays can create challenges for health care
4 providers to effectively deliver care and can create barriers to
5 health care access for patients.

6 The purpose of this Act is to:

7 (1) Lower the amount of time in which a health insurer may
8 initiate a recoupment or offset demand effort from a
9 health care provider for services rendered from
10 eighteen months to twelve months; and

11 (2) Establish other requirements that health insurers must
12 follow in making recoupment or offset demand efforts
13 from health care providers.

14 SECTION 2. Section 431:13-108, Hawaii Revised Statutes, is
15 amended to read as follows:

16 "**§431:13-108 Reimbursement for accident and health or**
17 **sickness insurance benefits.** (a) This section applies to
18 accident and health or sickness insurers issuing comprehensive
19 medical plans under part I of article 10A of chapter 431, mutual
20 benefit societies under article 1 of chapter 432, dental service

1 corporations under chapter 423, and health maintenance
2 organizations under chapter 432D.
3 (b) Unless shorter payment timeframes are otherwise
4 specified in a contract, an entity shall reimburse a claim that
5 is not contested or denied not more than thirty calendar days
6 after receiving the claim filed in writing, or fifteen calendar
7 days after receiving the claim filed electronically, as
8 appropriate.
9 (c) If a claim is contested or denied or requires more
10 time for review by an entity, the entity shall notify the health
11 care provider, insured, or member filing a claim from a non-
12 contracted provider in writing or electronically not more than
13 fifteen calendar days after receiving a claim filed in writing,
14 or not more than seven calendar days after receiving a claim
15 filed electronically, as appropriate. The notice shall identify
16 the contested portion of the claim and the specific reason for
17 contesting or denying the claim, and may request additional
18 information; provided that a notice shall not be required if the
19 entity provides a reimbursement report containing the
20 information, at least monthly, to the health care provider.

1 (d) Every entity shall implement and make accessible to
2 providers a system that provides verification of enrollee
3 eligibility under plans offered by the entity.
4 (e) If information received pursuant to a request for
5 additional information is satisfactory to warrant paying the
6 claim, the claim shall be paid not more than thirty calendar
7 days after receiving the additional information in writing, or
8 not more than fifteen calendar days after receiving the
9 additional information filed electronically, as appropriate.
10 (f) Payment of a claim under this section shall be
11 effective upon the date of the postmark of the mailing of the
12 payment, or the date of the electronic transfer of the payment,
13 as applicable.
14 (g) Notwithstanding section 478-2 to the contrary,
15 interest shall be allowed at a rate of fifteen per cent a year
16 for money owed by an entity on payment of a claim exceeding the
17 applicable time limitations under this section, as follows:
18 (1) For an uncontested claim:
19 (A) Filed in writing, interest from the first
20 calendar day after the thirty-day period in
21 subsection (b); or

1 (B) Filed electronically, interest from the first
2 calendar day after the fifteen-day period in
3 subsection (b);
4 (2) For a contested claim filed in writing:
5 (A) For which notice was provided under subsection
6 (c), interest from the first calendar day thirty
7 days after the date the additional information is
8 received; or
9 (B) For which notice was not provided within the time
10 specified under subsection (c), interest from the
11 first calendar day after the claim is received;
12 or
13 (3) For a contested claim filed electronically:
14 (A) For which notice was provided under subsection
15 (c), interest from the first calendar day fifteen
16 days after the additional information is
17 received; or
18 (B) For which notice was not provided within the time
19 specified under subsection (c), interest from the
20 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.

(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 demand 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

1 appeal of a recoupment or offset shall be made by a
2 health care provider within sixty days after the
3 receipt of the written notice[.]; provided that any
4 recoupment or offset demand not appealed within sixty
5 days after the receipt of the written notice shall be
6 deemed accepted by the health care provider.
7 (j) An entity shall not initiate recoupment or offset
8 demand efforts more than [eighteen] twelve months after the
9 initial claim payment was received by the health care provider
10 or health care entity; provided that this time limit shall not
11 apply to the initiation of recoupment or offset demand efforts:
12 to claims for self-insured employer groups; for services
13 rendered to individuals associated with a health care entity
14 through a national participating provider network; or for claims
15 for medicaid, medicare, medigap, or other federally financed
16 plan[; provided that this].
17 (k) This section shall not be construed to prevent
18 entities from resolving claims that involve coordination of
19 benefits, subrogation, or preexisting condition investigations,
20 or that involve third-party liability beyond the [eighteen]

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1 month time limit; provided [~~further~~] that [~~in~~] an entity shall
2 not:
3 (1) Initiate a recoupment or offset demand effort from a
4 health care provider, unless the entity does so in
5 writing to the health care provider within twenty-four
6 months after the date that the payment was made; or
7 (2) Request that a contested claim be paid any sooner than
8 six months after the health care provider receives the
9 request in writing.
10 Any recoupment or offset demand efforts initiated pursuant to
11 this subsection shall meet the written notice requirements
12 specified in subsection (i).
13 (l) In cases of fraud or material misrepresentation, an
14 entity shall not initiate recoupment or offset demand efforts
15 more than seventy-two months after the initial claim payment was
16 received by the health care provider or health care entity.
17 (m) An entity may, at any time, initiate a recoupment or
18 offset demand effort from a health care provider if:
19 (1) A third party, including a government entity, is found
20 to be responsible for satisfaction of the claim as a
21 consequence of any liability imposed by law; and

(2) The entity is unable to recover payment directly from the third party because the third party has either already paid or will pay the health care provider for the health services covered by the claim.

(n) Nothing in this section shall be construed to prohibit a health care provider from choosing at any time to return to an insurer any payment previously made to satisfy a claim.

(o) Nothing in this section shall be construed to prohibit an entity from recovering from an insured or a member beneficiary any amounts paid to a health care provider for benefits to which the insured or member was not entitled under the terms and conditions of the policy, plan, contract, or agreement.

[~~(k)~~] (p) 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)~~] (q) As used in this section:

"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 which the information in the possession of an entity adequately indicates that:

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

(2) The claim has no material defect or impropriety;

(3) There is no dispute regarding the amount claimed; and

(4) The payer has no reason to believe that the claim was submitted fraudulently.

[~~The term~~] "Clean claim" 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; 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

1 necessity of a service, liability of another payer, or other
2 grounds.
3 "Entity" means accident and health or sickness insurance
4 providers under part I of article 10A of chapter 431, mutual
5 benefit societies under article 1 of chapter 432, dental service
6 corporations under chapter 423, and health maintenance
7 organizations under chapter 432D.
8 "Fraud" shall have the same meaning as in section
9 431:2-403.
10 "Health care facility" shall have the same meaning as in
11 section 323D-2.
12 "Health care provider" means a Hawaii health care facility,
13 physician, nurse, or any other provider of health care services
14 covered by an entity."
15 SECTION 3. Statutory material to be repealed is bracketed
16 and stricken. New statutory material is underscored.
17 SECTION 4. This Act shall take effect upon its approval.
18

INTRODUCED BY: MAB

JAN 25 2023

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Report Title:
Insurers; Health Care Providers; Insurance Recoupment; Offset Demand Efforts

Description:
Lowers the amount of time in which a health insurer may initiate a recoupment or offset demand effort from a health care provider for services rendered from eighteen months to twelve months. Establishes other requirements that health insurers must follow in making repayment requests from health care providers.

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