LEGISLATIVE BILL 389

Approved by the Governor April 27, 2005

Introduced by Mines, 18; Redfield, 12; Kremer, 34; Price, 26

AN ACT relating to health care; to adopt the Health Care Prompt Payment Act.
Be it enacted by the people of the State of Nebraska,

Section 1. Sections 1 to 10 of this act shall be known and may be cited as the Health Care Prompt Payment Act.

Sec. 2. For purposes of the Health Care Prompt Payment Act:

(1) Claim form means an insurer's standard printed or electronic transaction form that complies with the standards issued by the Secretary of the United States Department of Health and Human Services or, if an insurer does not have a standard printed or electronic transaction form, any form which complies with such standards;

(2) Clean claim means a claim for payment of health care services that is submitted by a Nebraska health care provider to an insurer on a claim form with all required fields completed with information to adjudicate the claim in accordance with any published filing requirements of the insurer;

(3) Director means the Director of Insurance;

(4) Insurer means an entity that contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, a participant in an insurance arrangement as defined in section 44-4105, or any other entity providing a plan of health insurance, health benefits, or health care services. Insurer does not include the medical assistance program established pursuant to sections 68-1018 to 68-1025, a property and liability insurer, a motor vehicle insurer, a workers' compensation insurer, a risk management pool, or a self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(5) Prompt payment act compliance statement means a certification made in good faith by an insurer that, during the twenty-four-month period ending on the preceding June 30, it paid, denied, or settled more than ninety percent of its clean claims within the time periods set forth in subsections (1) and (2) of section 4 of this act;

(6) Repricer means an entity that receives claims from health care providers and submits them to insurers after adjudicating or repricing such claims; and

(7) Unfair payment pattern means any of the following patterns of conduct:

(a) Engaging in a demonstrable and unjust pattern of reviewing or processing complete and accurate claims that results in payment delays;

(b) Engaging in a demonstrable and unjust pattern of reducing the amount of payment or denying complete and accurate claims;

(c) Repeated failure to pay the uncontested portions of a claim within the time periods specified in section 4 of this act; or

(d) Failing on a repeated basis to pay the interest when due on claims pursuant to section 5 of this act.

Sec. 3. If a claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the insurer or the insurer's clearinghouse. If a claim is submitted by mail, the claim is presumed to have been received five business days after the claim has been placed in the United States mail with first-class postage prepaid. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

Sec. 4. (1) A clean claim shall be paid, denied, or settled within thirty calendar days after receipt by the insurer if submitted electronically and within forty-five calendar days after receipt if submitted in a form other than electronically.

(2) If the resolution of a claim requires additional information, the insurer shall, within thirty calendar days after receipt of the claim, give the health care provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The applicable time period set forth in subsection (1) of this section shall be tolled as of the date the additional information is requested until the date all such additional information

necessary to resolve the claim is received. The person receiving a request for such additional information shall submit all additional information requested by the insurer within thirty calendar days after receipt of such request. After such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the insurer within the remaining applicable time period set forth in subsection (1) of this section. Failure to furnish additional information within the time period required shall not invalidate or reduce the claim if it was not reasonably possible to give such information within such time period. The insurer may deny a claim if a health care provider receives a request for additional information and fails to submit additional information requested under this subsection.

(3) For purposes of subsection (1) of this section, a clean claim shall not include a claim:

(a) For which the insurer needs additional information in order to resolve one or more issues concerning coverage, eligibility, coordination of benefits, investigation of preexisting conditions, subrogation, determination of medical necessity, or the use of unlisted procedural codes; or

(b) For which the insurer has a reasonable belief supported by specific information that the claim has been submitted fraudulently.

(4) If a claim is submitted to a repricer, the time periods for payment, denial, or settlement of such claims set forth in this section shall commence upon receipt of the claim by the repricer.

Sec. 5. (1) An insurer that fails to pay, deny, or settle a clean claim in accordance with the time periods set forth in subsection (1) of section 4 of this act or to take other required action within the time periods set forth in subsection (2) of section 4 of this act shall pay interest at the rate of twelve percent per annum on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to section 4 of this act.

(2) To the extent that interest is not paid concurrently with the claim, it may be paid on a quarterly basis or when the aggregate interest for a health care provider exceeds ten dollars.

Sec. 6. An insurer shall be exempt from the requirements of section 5 of this act during a calendar year when the insurer has a prompt payment act compliance statement on file with the director. Any insurer desiring to obtain the exemption shall file a prompt payment act compliance statement with the director not later than December 1 of the year prior to the exemption year. A list of insurers with prompt payment act compliance statements on file shall be publicly available from the director.

Sec. 7. If an insurer delegates its claims processing functions to a third party, the delegation agreement shall provide that the third party shall consent to an examination and cooperate with that examination by the director and shall comply with the requirements of the Health Care Prompt Payment Act. Any delegation by the insurer shall not be construed to limit the insurer's responsibility to comply with the act.

Sec. 8. (1) An insured, a representative of an insured, or a health care provider acting on behalf of the insured may notify the director of activities related to an unfair payment pattern. The director shall compile a record of notices, and if it appears to the director that an insurer, or a third party working on behalf of an insurer, may be engaged in an unfair payment pattern or that an insurer has filed a prompt payment act compliance statement that the insurer knows or has reason to know is false, the director may examine and investigate the affairs of such insurer or third party, either as part of a regularly scheduled examination or as part of an examination called solely for the purposes of determining compliance with the Health Care Prompt Payment Act. The insurer shall reimburse the Department of Insurance for the expense of the examination of the insurer or third party working on behalf of the insurer in the same manner as provided for examination of insurance companies in the Insurers Examination Act.

(2) If as a result of an examination conducted under subsection (1) of this section, the director finds that any insurer doing business in this state is engaged in any unfair payment pattern, or that the insurer has filed a prompt payment act compliance statement that the insurer knows or has reason to know is false, and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such insurer a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days from the date of the notice.

(3) If, after a hearing conducted pursuant to the Administrative Procedure Act, the director finds that an insurer or a third party working on behalf of an insurer has engaged in an unfair payment pattern or that the

insurer has filed a prompt payment act compliance statement that the insurer knows or has reason to know is false, the director shall reduce the findings to writing and shall issue and cause to be served upon the insurer a copy of the findings and an order requiring the insurer or any third party working on behalf of the insurer to cease and desist from engaging in the act or practice and the director may order any one or more of the following:

(a) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Health Care Prompt Payment Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars;

(b) Suspension or revocation of the insurer's license or certificate of authority if the insurer knew or reasonably should have known it was in violation of the act; and

(c) Withdrawal of the insurer's prompt payment act compliance statement for such time as the director determines.

(4) Any insurer who violates a cease and desist order under subsection (3) of this section may, after notice and hearing and upon order of the director, be subject to:

(a) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(b) Suspension or revocation of the insurer's license or certificate of authority.

Sec. 9. The Health Care Prompt Payment Act does not apply to any individual or group policies that provide coverage for a specific disease, accident-only coverage, hospital indemnity coverage, disability income coverage, medicare supplement coverage, long-term care coverage, or other limited-benefit coverage. The act does not apply to any claim submitted before January 1, 2006.

Sec. 10. The director may adopt and promulgate rules and regulations to carry out the Health Care Prompt Payment Act.