



**Ninety-Eighth Legislature - Second Session - 2004**  
**Committee Statement**  
**LB 334**

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**Hearing Date:** February 24, 2003

**Committee On:** Banking, Commerce and Insurance

**Introducer(s):** (Kremer, Jensen, Tyson)

**Title:** Provide for prompt payment by health and accident insurers

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**Roll Call Vote – Final Committee Action:**

Advanced to General File

Advanced to General File with Amendments

X Indefinitely Postponed

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**Vote Results:**

6	Yes	Senators Quandahl, Tyson, Foley, Louden, Mines, Redfield
	No	
2	Present, not voting	Senators Jensen, Johnson
	Absent	

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**Proponents:**

Senator Bob Kremer  
 David Filipi, M.D.  
 Dr. Keith Shuey

Michael Kasher

Christine Moss  
 Roger Keetle  
 Mark Dillman  
 Larry Ruth

**Representing:**

Introducer  
 NE Medical Association  
 NE Medical Association  
 South East Rural Physician Alliance  
 NE Medical Group Management Association  
 Lincoln Pediatric Associates, P.C.  
 NE Spine Center, LLP  
 NE Hospital Association  
 Mary Lanning Memorial Hospital  
 NE Dental Association

**Opponents:**

Matt Ellis  
 Thomas Jenkins  
 Galen Ullstrom  
 William Peters  
 Janis McKenzie  
 Loy Todd

**Representing:**

Midlands Choice  
 Blue Cross/Blue Shield of NE  
 Mutual of Omaha Insurance Co.  
 Golden Rule Insurance  
 NE Insurance Federation  
 NE New Car & Truck Dealers Association

**Neutral:**

**Representing:**

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**Summary of purpose and/or changes:**

LB 334 (Kremer, Jensen, Tyson) would enact nine new sections to be known as the Health Care Prompt Payment Act.

The bill would provide, section by section, as follows:

Section 1 would provide for a named act: the Health Care Prompt Payment Act.

Section 2 would provide definitions for terms: “insurer;” “clean claim” (a claim for payment of health care services submitted to an insurer on the insurer’s standard printed or electronic transaction form with correct and complete information); “unfair payment pattern” (an unjust pattern of reviewing or processing complete and accurate claims that results in payment delays; an unjust pattern of reducing the amount of payment or denying complete and accurate claims; repeated failing to pay the uncontested portion of a claim within the time frames specified in section 4 of the bill; and repeated failing to pay the interest or late fees when due on claims pursuant to section 5 of the bill).

Section 3 would provide that an electronically submitted claim is presumed to have been received on the date of the electronic verification of receipt by the insurer. This section would provide that an insurer shall make a mechanism available to providers to enable them to confirm the receipt of a claim filed with the insurer in a manner other than electronically, and that such claim shall be deemed received on the date it is listed on the notification mechanism by the insurer.

Section 4 would provide time frames for the payment of claims in three subsections:

Subsection (1) would provide that clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the insurer.

Subsection (2) would provide that if the resolution of a claim requires additional information, the insurer shall, within thirty calendar days after receipt, give the provider, policyholder, insured, or patient, as appropriate, a written explanation of what additional information is needed; that the person receiving a request for such additional information shall submit all additional information requested within thirty days after receipt of such request; that the insurer may deny a claim if a provider fails to submit additional information requested under this subsection; that if the person receiving a request for additional information has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled within ninety calendar days; and that, absent fraud, all clean claims shall be paid, denied, or settled within ninety calendar days after receipt by the insurer.

Section 5 would provide that an insurer that fails to pay, deny, or settle a clean claim within thirty calendar days or fails to take other required actions within the time periods set forth in the case of claims for which additional information is required, shall pay to the insured or health care provider, with proper assignment, interest at the rate of twelve percent annually on the total amount ultimately allowed, accruing from the date payment was due; and that an insurer that otherwise fails to pay, deny, or settle a claim within ninety days after receiving the claim

shall pay to the insured or health care provider, with proper assignment, a late fee in an amount equal to ten percent of the total amount ultimately allowed on the claim.

Section 6 would provide that if an insurer delegates claims processing functions to a third party, the claims processing entity shall comply with this act.

Section 7 would provide that engaging in an unfair payment pattern shall constitute an unfair claims settlement practice under the Unfair Insurance Claims Settlement Practices Act.

Section 8 would provide that a complaint under the Unfair Insurance Claims Settlement Practices Act concerning a claim for services by a health care provider or an unfair payment pattern may be submitted by the insured, the insured's representative, or the provider acting on behalf of the insured.

Section 9 would provide the Director of Insurance with rule and regulation authority to carry out the act.

**Explanation of amendments, if any:**

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**Senator Mark Quandahl, Chairperson**