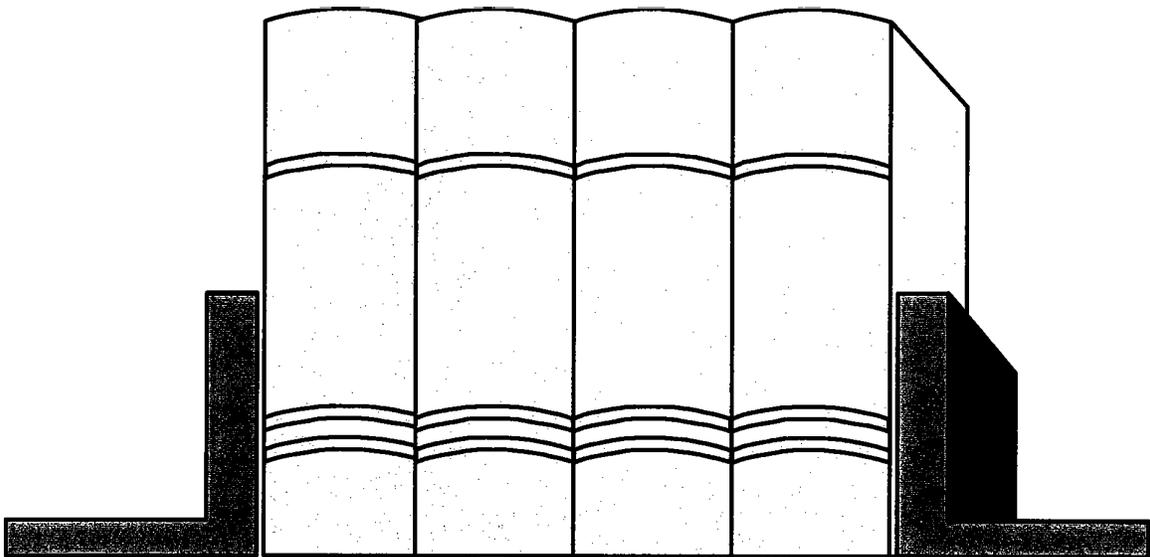


AAOS

American Association of
Orthopaedic Surgeons

Resource Guide On Prompt Payment





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TAB 1



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Position Statement

Prompt Payment of Physician Claims

Timely Payment of Uncontested Claims

Many physicians are often not paid in a timely manner for health care services rendered to patients. They and their staff must, therefore, spend an extraordinary amount of time and effort on reimbursement issues to the detriment of their appropriate focus, which is patient care. Insurance carriers and health plans unreasonably delay payments to physicians for many months, as well as arbitrarily reduce payments without proper cause. Orthopaedic offices report that accurate and valid claims may remain unpaid for more than 90 days. Many insurers also delay payment of larger claims by finding minor errors in ancillary portions of the claim.

The American Association of Orthopaedic Surgeons (AAOS) supports prompt payment of uncontested claim by government agencies, insurance companies and managed care plans within a 30-day time period. The AAOS also supports the prompt payment of any part of a claim that is complete and undisputed. Whenever possible, the AAOS encourages electronic claims submission and resolution.

Notification of Deficient Claims

Third-party payers often dispute claims on the basis that patient care services were not medically necessary or that the method in which health care services were accessed or made available contradicted the managed care contract. When a carrier contests a claim or delays payment because more information is needed, frequently physicians are not given notice in a timely manner. When further documentation is requested, and the physical provides the information, an insurer or health plan can further delay payment by asking for additional information or clarification. Reprocessing these claims is a time-consuming process, resulting in increased practice overhead expense.

The AAOS believes insurance companies and managed care plans should notify physicians promptly if a claim is in dispute or the payer desires additional information. This notification should describe all problem with a claim, and give the physician an opportunity to respond to all problems at the time of initial notification. Contracts with managed care organizations should clearly define standards for billing, deficiency notification, and timely payment of claims.

Penalties,, Sanctions, Regulatory Oversight

In an effort to alleviate problems of untimely payment, some state legislatures and insurance commissions have. stepped in to assure prompt payment of claims. One common legislative proposal is the payment of a monthly or yearly interest penalty on late claims.

The AAOS urges state legislatures and insurance commissions to enact or strengthen prompt payment regulations. These regulations should address standards for claims processing and management, as well as establish sanctions against carriers who have a policy or practice of late payments. State insurance commissioners should be held accountable for enforcement of defined standards.

The AAOS urges its membership to take an active interest in prompt payment issues, and encourages the efforts of state medical societies on behalf of this issue.

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(Home Position Statements)

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<http://www.aaos.org/wordhtml/papers/position/1151.htm>

Subject: Finance
Title: Prompt Payment

Date:
08/16/2000

By: Molly Stauffer

Updated By: Rachel Morgan

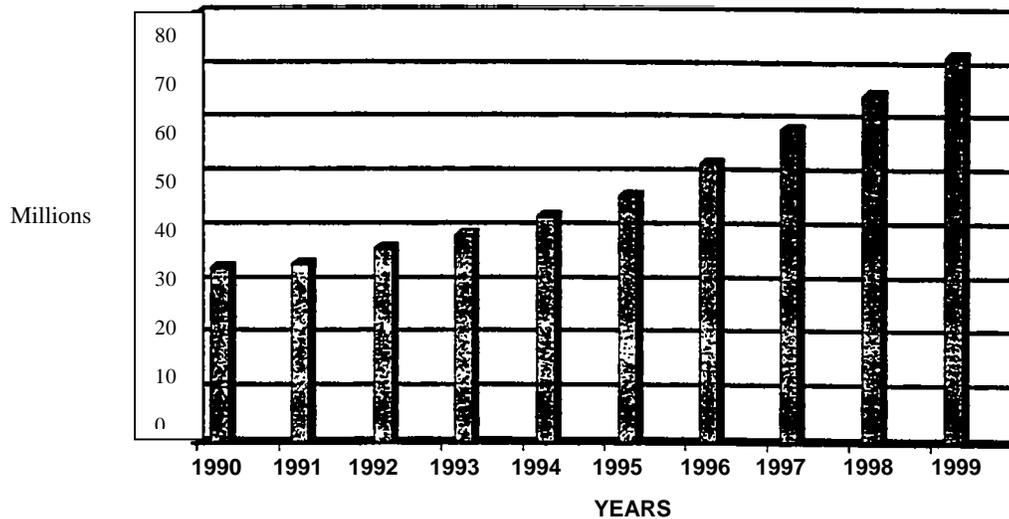
Although withholding prompt payment is considered an unfair trade practice, under standard business laws, a number of states are enacting new laws or clarifying existing language to ensure that health plans are paying providers in a timely fashion.

OVERVIEW

Increased demand for affordable healthcare has dictated rapid growth in enrollment for managed care plans (see figure 1).

Figure 1.

Pure Enrollment and Growth Rate



Source: The Interstudy Competitive Edge Part U: HMO Industry Report, (St Paul, Minnesota: Interstudy Publications, October 1998).

In a 1997 survey (conducted by the Commonwealth Fund) of physician's experience with managed care, nine out of 10 physicians (87 percent) had some managed care patients, and 22 percent said that managed care patients accounted for more than half their practice. It revealed that generalists have a greater share of managed care patients (37 percent), on average, than do specialists (30 percent). In addition, physicians were participating/contracted with multiple plans. Half of physicians reported having five or more contracts; only 10 percent worked with single plans.

The type of health maintenance organization (HMO) with which a provider contracts—group model, network model or staff model—will dictate his or her reimbursement. Most physicians in staff model HMOs serve HMO enrollees exclusively, often in HMO-owned clinics. Physicians usually are paid on a salary or fixed amount per enrollee for providing comprehensive health services. The group model HMO contracts with one or several large physician group practices. Most primary care physicians (PCP) are capitated, although a significant number—approximately 35 percent—are paid on some kind of discounted fee for service, or per case, basis. The majority of specialists still are paid on a fee for service or per case basis, although some are paid on a capitated basis (1).

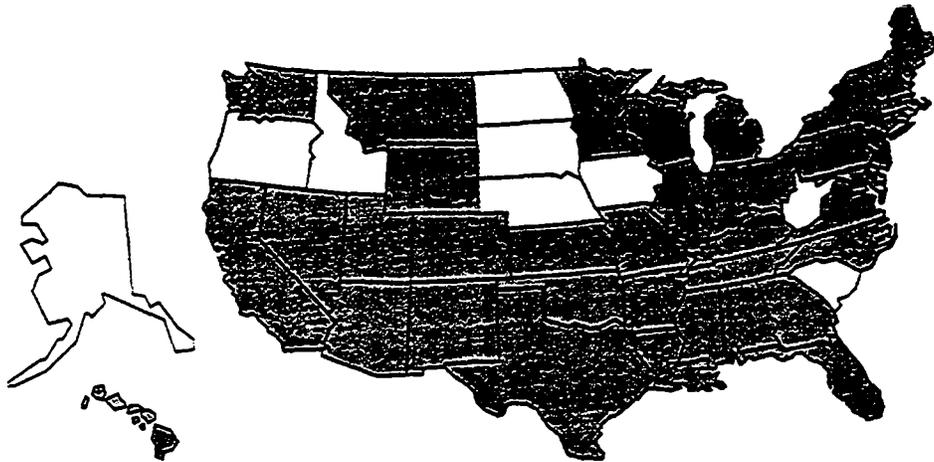
Additional forms of compensation beyond monthly capitation for the PCP, and fees collected by the specialist, most often come in the form of patient copays collected at the time of service. Many of the larger managed care organizations are also providing PCP incentives based on quality of care criteria, such as if the practice is providing health promotional information to their patient.

Despite the model, or mode of reimbursement, state lawmakers are increasing efforts to make sure health plans pay providers for submitted clean claims in a timely fashion.

As of this report, 40 states - **Alabama, Arizona, Arkansas, California, Connecticut, Colorado, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin and Wyoming**- have put health insurers on notice to pay clean claims in a timely fashion or face possible penalties and fines (see figure 2). Although most states require insurers to pay clean claims" within 45 days, state requirements range from as quickly as 15 days to as long as 60 days.

Figure 2.

Prompt Payment (40 States)



Source: Health Policy Tracking Service, National Conference of State Legislatures, August 2000.

RECENT LEGISLATIVE ACTIVITY

The 1999 Legislative Sessions

In 1999, at least 24 states introduced bills, and new requirements were adopted in numerous statehouses.

A Virginia law requires claims to be paid within 40 days. If the claim is disputed, the carrier must request information sufficient to process the claim or make a final determination within 30 days. The request may be submitted electronically or in writing to the claimant.

According to **Virginia** law, "clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) that substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with the section.

Georgia's law requires a managed care plan to make full and timely reimbursement to any health care provider in the same manner and subject to the same penalties as required of insurers for group accident and sickness insurance policies under paragraph (5) of Code Section 33-30-6.

Under current law (Official Code of Georgia Annotated, Section 33-30-61), carriers are required to pay for benefits immediately upon "receipt of due written proof of such loss." If the insurer fails to pay for the benefits, the insurer has 15 working days to mail the subscriber a letter or notice that states the reasons the insurer has failed to pay the claim and a written itemization of any documents needed to process the claim. When all the necessary documents are received, the insurer will have 15 working days in which to pay or deny the claim, giving the subscriber the reasons for denying the claim or any portion of the claim.

In Colorado a law was enacted to require clean claims be settled within 30 days if submitted electronically and within 45 days if submitted by other means. The law took effect Jan. 1, 2000. According to sources in the state, "there will be some implementation issues," when it comes to enforcement, since state authorities cannot get involved in contract issues. Currently, through regulatory authority, claims are required to be paid in 60 days by insurers. According to the same source, the regulations will be amended this fall. The 60-day payment requirement will remain in effect, though, for property and casualty insurance.

Although **Texas** already requires clean claims to be paid within 45 days, a law was enacted (House Bill 610) that, in addition to provisions regarding payment of clean claims, requires a prescription benefit claim, that is electronically adjudicated and electronically paid, to be paid no later than the 21st day after the treatment is authorized.

Minnesota Governor Jesse Ventura (Reform) signed legislation (Senate 1268) that requires HMOs to pay or deny a home health care claim within 30 days of receipt. HMOs will be required to pay interest at the rate of 1.5 percent per month on all claims not paid in the required time.

New Jersey lowered its requirement from 60 days to 30 days for electronic claims and to 40 days for all claims submitted by other means.

This brings up a new aspect of the payment process that state lawmakers are beginning to examine: Should there be different standards for electronic versus nonelectronic claims? HPTS has identified at least eight states that have established different standards for electronic versus nonelectronic claims (see table 1).

Table 1.

State	Electronic Payment	Other Means
Colorado	30 days	45 days
Hawaii	15 days	30 days
Louisiana	25 days	45 days
New Hampshire	15 days	45 days
New Jersey	30 days	40 days (1)
New Mexico	30 days	45 days
Tennessee	21 days	30 days
Texas	21 days (2)	45 days

(1) 40 days if submitted within 45 days. 60 days if submitted after 45 days. (2) Prescription benefit claims only.

Laws also were enacted in Florida, Hawaii, Louisiana, **Nevada, North Carolina, Pennsylvania, Tennessee, Vermont** and **Wisconsin**.

New Mexico Governor Gary Johnson (R) vetoed three separate bills containing provisions to ensure timely payments to providers. In his veto message for one of the bills--Senate Bill 403--the governor stated that he vetoed the bill because current state law and Insurance Department rules already contain a requirement for payment in 45 days and allow for the imposition of penalties for failing to make timely insurance claims. 'I am concerned that this bill may increase the cost of providing health care by imposing new requirements on HMOs and establish a precedent for government involvement in private contracts,' Johnson stated. As proposed, the bill imposed an interest penalty on the HMO if it does not pay the undisputed portion of any claims within 30 days.

Other activity includes a number of amendments to existing language regarding prompt payments. This includes, but is not limited to, a law in **Oklahoma** that specifies that in cases where a claim has not been paid within six months after receipt of proof, an insurer is required to pay interest at a rate equal to the average U.S. Treasury Bill rate of the preceding calendar year plus 4 percentage points. Interest will be calculated from the 61st day after receipt of loss, until the claim is paid. The state's HMO rules require claims be paid within 30 days.

The 2000 Legislative Sessions

In 2000, the statehouses again are giving this issue serious consideration. At least 21 states have considered proposals and several have been enacted.

New Mexico lawmakers agreed on new prompt payment requirements. Although the state currently requires managed health care plans to pay claims within 45 days, Senate Bill 164 requires a health plan to pay electronically submitted clean claims within 30 days. The bill was signed by the governor in early March.

Other activity includes new laws in **Arizona, Kansas** and **Kentucky** requiring clean claims payment within 30 days. Most recently, **Massachusetts** enacted legislation allowing 45 calendar days for clean claims processing. **New Hampshire** enacted that claims submitted in writing should be paid within 45 days and electronic submissions in 15 days.

New Hampshire defines a "clean claim" as: a claim for payment of covered health care expenses that is submitted to a health carrier on the carrier's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements.

Prior to the start of the 2000 session, **Minnesota** had a law on the books that requires home health claims covered by HMOs to be paid within 30 days. With the enactment of Senate Bill 2767 all health plan companies and third-party administrators are required to pay claims within 30 days.

Tennessee expanded prompt payment mandates enacted in 1999 which covered only HMOs participating in TennCare to include all provider claims for covered services delivered to eligible health insured patients. This new legislation also differentiates requirements of processing payments electronically and other methods of submitting claims.

FEDERAL ACTIVITY

The U.S. Congress again considered several bills in 1999 to strengthen protections for consumers enrolled in managed care. Table 2 summarizes the prompt payment provisions contained in both the House and Senate patient protection acts. A conference committee is looking at the issue.

Table 2.
Comparison of Federal Proposals

Provision	HOUSE BILL H.R. 2990	SENATE BILL S.1344
Prompt Payment	Requires that claims be paid in accordance with Medicare guidelines for prompt payment. ¹	No provision.

(¹) Federal Medicare law requires that payment shall be issued, mailed or otherwise transmitted with respect to not less than 95 percent of all claims submitted: (1) which are clean claims, and (2) for which payment is not made on a periodic interim payment basis, within 30 calendar days after the date on which the claim is received. The term 'clean claim' means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part. If payment is not issued, mailed, or otherwise transmitted within 30 calendar days after a clean claim is received, interest must be paid for the period beginning on the day after the required payment date and ending on the date on which payment is made.

KEY ISSUES

Proponents state these provisions ensure timely payment of clean claims. In a January 31, 1999, article in the *Atlanta Journal and Constitution*, the Georgia Hospital Association was quoted as stating that insurers averaged 69 days to pay a "clean claim," with some hospitals reporting delays as long as 169 days. David Cook, legislative counsel for the Medical Association of Georgia, stated in the same article that he believes *delays in claims payments "... is an intentional effort at getting money on the float"--an extra month or two to invest for the managed care company* ⁽²⁾. Additionally supporters encouraged expanding the legislation to address concerns over untimely notification of denials, and unclear or complicated explanation of benefit dispersion.

Opponents fear, prompt payment provisions are further efforts by government to micro-manage interaction between insurers and providers. The legislation has been called by some "heavy-handed," and has been criticized for failing to take into account third parties' frequent billing mistakes ⁽³⁾. It is felt that there must be a clear establishment of criteria for what constitutes a clean claim. Concerns over requirements by prevailing authorities that the insurer provide evidence of improper filing or incur fines and penalties, and that strict notification requirements will be costly and time consuming are among other issues expressed.

Legislators are considering many of these factors. With an emerging consistency, many states enacting legislation include clearly defined criteria for clean claims . They have also allowed for variances from mandated time frames based on terms established in contractual agreements between the provider and insurer, and instances where the provider may have been non-compliant with regulatory submission requirements. Some states established notification guidelines in order to require the managed care plans to provide simply stated information to covered persons and providers necessary to inform them of denied or covered benefits and services.

TYPICAL PROVISION

Typically prompt payment provisions require a licensed insurer to pay a clean claim submitted by a provider within 'X' number of days. If the clean claim is not paid within "X" number of days , interest at 'Y' percent will be added to the amount. Notification requirements are outlined if it does not fall under the criteria of a clean claim in order to report the status. The notice usually is required to include the specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim. Interest, in most cases, begins on day 'X.' If there are allowances for a variance from the provisions they are also provided for in the language.

DEFINITIONS

Capitation: A fixed rate of payment for all necessary services over a fixed period of time for a defined population (e.g., HMO membership in a specified zip code area). The rate is usually provided on a per member per month (PMPM) basis , whether service is provided or not, with adjustments for age, sex and family size. Often called a "cap".⁽⁵⁾

Case Rates: A flat rate fee schedule based on a fixed amount per patient, often by diagnosis, and especially for inpatient care.⁽⁵⁾

Clean Claim: A claim that can be processed in accordance with a health plan's procedures without obtaining additional information from the health care provider or from a third party.⁽⁴⁾

Copayment: Payment of a flat dollar amount per unit of service at the time of the service (e.g. \$10 per physician office visit). The amount paid is usually nominal, but may be sufficient to provide an incentive to appropriately utilize health services. It is also an additional source of income to the provider.⁽⁵⁾

Group Model HMO: The HMO contracts with a single multi-specialty medical group. The group practice may work exclusively with the HMO, or may serve non-HMO patients as well.⁽⁴⁾

Network Model: The HMO contracts with more than one medical group. Some network models are hybrid and share features of both the group and independent practice association (IPA) model.⁽⁴⁾

Staff Model HMO. Physicians are employed directly by the HMO and deal exclusively with HMO members.⁽⁴⁾

Mixed Model HMO: Any of the above, including point of service, which allows patients to opt out of the system in exchange for paying higher premiums and co-payments.⁽⁴⁾

Fee for Service: The traditional way by which health care services were paid in the United States before the rapid growth of managed care. A method of charging for each visit or service. The fees are paid after the service is provided either by indemnity insurance, or out-of-pocket by the patient, or some combination of both. ⁽⁴⁾

Fixed Rate: The provider is paid a certain amount per case, often by diagnosis, for providing services regardless of the actual volume of services used or needed. May be termed contact capitation. ⁽⁵⁾

Notes:

(1) The Commonwealth Fund, *Survey of Physician Experiences in Managed Care*, (New York, N.Y.: The Commonwealth Fund, 1997).

(2) A. Miller, 'Doctors Angry at HMOs, Insurers: Frustration Over Trimmed Fees, Unpaid Claims has Spawned Proposed Legislation,' *The Atlanta Journal and Constitution*, January 31, 1999.

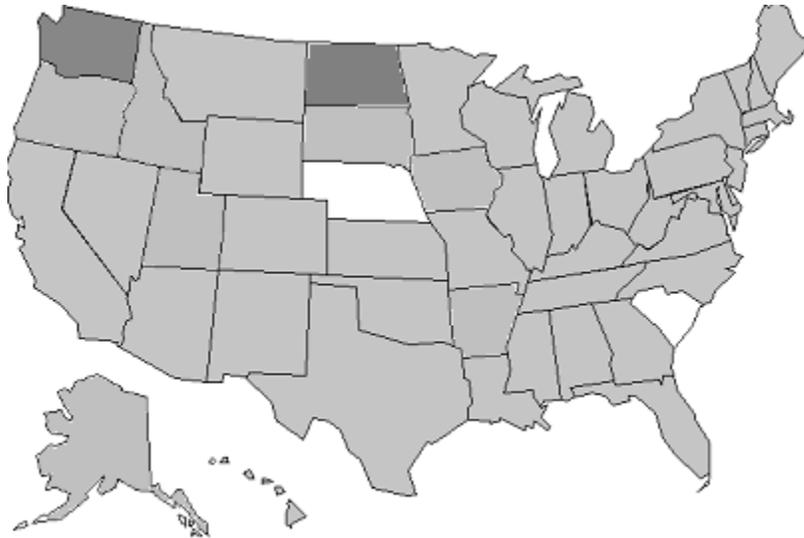
(3) M. Vadum, 'Bills Demand Speedier Health-Claims Payment,' *Central Penn Business Journal*, May 1, 1998.

(4) E. Freudenheim, *HealthSpeak, A Complete Dictionary of America's Health Care System*, (New York, N.Y.: Facts on File, Inc., 1996).

(5) M. D. Bischel, MD, *Utilization Management and Capitation Strategies*, (Santa Barbara: Apollo Managed Care Consultants, 1998).

TAB 2

PROMPT PAYMENT LAWS



Light Grey: Prompt Payment Legislation

Dark Grey: Prompt Payment Regulation

As of 5/01/2004

Prepared by AAOS Department of Socioeconomic and State
Society Affairs

PROMPT PAYMENT

Forty-five states have passed legislation that covers prompt payment for health provider claims:

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin and Wyoming.

Washington has a prompt pay regulation.

Alabama - All insurers must pay paper claims within 45 days after receipt and electronic claims within 30 days or face an interest penalty of 1.5% per month.

Alaska - Claims must be paid within 30 days or interest is charged at 15%.

Arizona - Payment must be made within thirty days after receipt or as specified in contract or interest can be assessed at the legal rate.

Arkansas - Claims must be paid within 60 days with interest at 12%.

California - Claims must be paid within 30 days or 45 days for a HMO with late fees being assessed at a rate of 10% per year.

Colorado - Electronic claims must be paid within 30 days and paper claims must be paid within 45 days or an interest penalty of 10% will be assessed.

Connecticut - Under the Unfair Business Practice Act claims must be paid within 45 days or fines will be assessed at 15%.

Delaware - Under the Unfair Business Practice Act claims must be paid within 45 days after receipt or interest can be charged at the maximum rate allowed by law.

Florida - Claims must be paid within 35 days or interest can be assessed at 10%.

Georgia - Claims must be paid within 15 working days of receipt with late interest accruing at the rate of 18%.

Hawaii - Paper claims must be paid within 30 days and electronic claims must be paid within 15 days or interest accrues at 15 %.

Idaho – Paper claims must be paid within 45 days and electronic claims within 30 days or interest accrues at 12%

Illinois - Claims must be paid within 30 days and late interest is 9%.

Indiana - Medicaid claims must be paid within 21 days for electronic claims or 30 days for paper claims with interest accruing thereafter at the average investment yield on state money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report. Other electronic claims must be paid within 30 days and paper claims must be paid within 45 days.

Kansas - Claims must be paid within 30 days with interest penalties of 1% per month.

Kentucky - Claims must be paid within 30 days with interest accruing at the rate of 12 % during days 31-60, 18% for days 61-90 and 21% for days 91 and beyond.

Louisiana - Electronic claims must be paid within 25 days, paper claims submitted within 45 days of service must be paid within 45 days, and paper claims submitted after 45 days of service must be paid within 60 days. Interest accrues at the rate of 12% on late payments.

Maine - Claims must be paid within 30 days or interest accrues is 1.5% per month.

Maryland - Claims must be paid within 30 days and interest grows from 1.5% per month from day 31 to 60, to 2% per month for days 61 to 120 and 2.5% per month after day 121.

Massachusetts - Claims must be paid within 45 days or interest accrues at 1.5% per month.

Michigan - Medicaid claims must be paid within 45 days or interest accrues at 12%.

Minnesota - Claims must be paid within 30 days or interest accrues at 1.5% per month.

Mississippi - Claims must be paid within 45 days with 18% interest for late payments.

Missouri - Claims must be paid within 45 days with interest accruing thereafter at 12%.

Montana - Under the Unfair Trade Practices Act claims must be paid within 30 days with interest accruing at a rate of 18% only if the commissioner determines the delay was unreasonable.

Nevada - Claims must be paid within 30 days with interest accruing thereafter at the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date of the transaction, plus 6 percent.

New Hampshire - Electronic claims must be paid within 15 days and paper claims within 45 days or interest accrues at 1.5% per month.

New Jersey - Electronic claims must be paid within 30 days and paper claims within 40 days or interest accrues at 10%.

New Mexico - Electronic claims must be paid within 30 days and paper within 45 or interest accrues at 18%.

New York - Claims must be paid within 45 days or interest accrues at 12%.

North Carolina - Claims must be paid within 30 days or interest accrues at 18%.

Ohio - Claims must be paid within 30 days with interest accruing thereafter at 18%.

Oklahoma - Interest starts accruing 45 calendar days after submittal of a claim at 10%.

Oregon - All claims must be paid within 30 days and interest accrues at 12%.

Pennsylvania - Claims must be paid within 45 days with 10% interest on late payments.

Rhode Island - Paper claims must be paid within 40 days and electronic claims within 30 days. Late interest accrues at 12%.

South Dakota - Paper claims must be paid within 45 days and electronic claims must be paid within 30 days.

Tennessee - Electronic claims must be paid within 21 days and paper claims within 30 or interest accrues at 1% per month.

Texas - Claims must be paid with 45 days or interest accrues at 18%.

Utah - Claims must be paid within 30 days. Late interest accrues at .1% for the first 90 days and at the rate of 10% thereafter.

Vermont - Claims must be paid within 45 days with interest thereafter at 12%.

Virginia - Claims must be paid within 40 days or interest accrues at the legal rate.

West Virginia - Electronic HMO claims must be paid within 30 days and paper HMO claims within 40 days with late interest at 10%.

Wisconsin - Claims must be paid within 30 days or interest accrues at 12%.

Wyoming - Claims must be paid within 45 or interest accrues at 10%.

PROMPT PAYMENT

State	Prompt Pay Law	“Clean Claim” Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Alabama	Yes Ala. Code §27-1-17	Yes (clean electronic claim and clean written claim)	No	45 calendar days of receipt	30 calendar days of receipt	Insurer, health service corporation and health benefit plan must: 1) Notify provider within 45/30 calendar days of the reason for denial; 2) specify what additional information is required; 3) pay undisputed portion; 4) pay, deny or otherwise adjudicate claim within 21 calendar days after receipt of requested information	1.5% per month	Commissioner may assess administrative fines if pattern of overdue payments is established; fines up to \$1000/day not to exceed \$100,000 per violation. Fines deposited in general fund for use by the Dept. of Insurance	No violation if claim is submitted more than 180 days after services were rendered Insurer, health service org and health benefit plan cannot retroactively deny, adjust or seek refund of a paid claim after the expiration of one year from the date the initial claim was paid or whatever terms are in the contract Other – Refunds of paid claims by insurers are barred after the expiration of 12 months from date of payment. Insurer cannot avoid this requirement via their contracts with the provider.
Alaska	Yes Alaska Stat. § 21.54.020	Yes	No	30 calendar days after receipt	Same	Insurer must give notice of the basis for denial or the specific items necessary for the claim to be adjudicated to the covered person within 30 calendar days. If such notice is not given, claim is presumed clean	Maximum rate provided for the financing of premiums under state law	--	Payment may be made directly to the provider upon written request of a covered person; claim considered paid on the day payment is mailed or transmitted electronically
Arizona	Yes Ariz. Rev. Stat. Ann. §§ 20-3101, 20-3102	Yes	No	30 days after receipt, or as specified in contract	Same	Insurer must: 1) Send written request for additional information within 30 days of receipt; 2) specify reasons for delay in processing; 3) approve/deny claim within 30 days after receipt of additional info. or as specified in contract	Legal rate	Insurers must provide semi-annually to director a report of grievance resolutions. Director may examine insurers with significant numbers of unresolved grievances Administrative remedies for violations of this section	Specifically applies to third party intermediaries <i>Nothing contained in this section is intended to provide any private right or cause of action to or on behalf of any insured or uninsured resident or nonresident of this state</i>

State	Ste	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Arkansas		Yes (reg) Ark. Reg. 43 Ark. Code Ann. § 23-66-215	Yes	No	45 days after receipt	30 days after receipt	Notify within 30 days after receipt of claim if additional info is needed; shall give explanation of the additional information that is required; health carrier may suspend the claim until it receives the requested info (or the EOMB – in the case of a Medicare supplement policy); shall reopen and pay or deny a previously suspended claim within 30 days after all request info is received	12% per annum	Health Carrier shall strive to meet specified standards for processing all claims; if evidence shows that the Health Carrier has fallen below the regulatory action standards, a series of remedies exist, including (1) submitting a remedial action plan, (2) contacting providers re delays in Health Claim processing and informing of steps being taken to improve this status, (3) providing a claim processing report on a monthly basis until standards are met and (4) other remedies or actions.	
California		Yes Cal Health & Safety Code §§ 1371 et seq.	No	No	30 working days after receipt (45 days for HMOs)	Same	Plan must: 1) Notify (in writing) within 30 days of receipt if contested/denied (45 days for HMOs); 2) pay undisputed portion of the claim; 3) identify portion of claim that is contested and specific reasons for contesting/denying; 4) pay within 30 days (45 for HMOs) after receipt of necessary information	15% per annum	Director may impose penalties and require plans to pay within shorter timeframe than required by law, upon finding that plan engaged in an unfair payment pattern	Defines a "reasonably contested" claim; imposes penalties for plan downcoding; requires plans to create dispute resolution mechanisms; requires that plans ensure that mechanisms are accessible to noncontracting providers for the purpose of resolving billing/claims disputes
Colorado		Yes Colo. Rev. Stat. § 10-16-106.5	Yes	Yes	45 calendar days after receipt	30 calendar days after receipt	Carrier must: 1) Notify within 30 calendar days of receipt; 2) full explanation of what info. is needed – in writing; 3) dispense of claim within 90 calendar days of initial receipt	Re clean claims - 10% per annum on the total amnt ultimately allowed on the claim, accruing from the date payment was due.	If not paid/denied/settled within 90 days after receiving claim, 10% of total amnt ultimately allowed on the claim; penalty imposed on 91 st day after receipt	Retroactive denials allowed in certain cases; carrier may deny claim if additional info. requested is not received within 30 days of request Regarding the delegation of claims payment to a third party payer, the delegated

									entity is to comply with all payment processing laws as if they were the insurer. Any delegation by the carrier will not be construed to limit the carrier's responsibility to comply with the law
Connecticut	Yes Conn. Gen. Stat. § 38a-816(15), § 38a-477	No	No	45 days after receipt, or as stipulated by contract	Same	Insurer shall (1) send written notice of all alleged deficiencies in information needed not later than 30 days after insurer receives claim and (2) pay claims for payment or reimbursement under the contract no later than 30 days after the insurer receives the info requested	15% per annum	Penalties assessed pursuant to Unfair Business Practice Act	Whenever interest due is less than \$1.00, the insurer shall deposit the amount in a separate interest-bearing account; at end of each year, money is to be donated to The University of Connecticut Health Center
State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Delaware	Yes Del. Dept. of Insurance, Reg. 1310 (effective July 1, 2003)	Yes	No	45 days after receipt	30 days after receipt	Health insurer to pay all portions of claim that are clean within 30/45 days after receipt; shall notify, in writing, within 30 days of receipt (1) that carrier is not obligated to pay – in whole or in part – stating specific reasons why; or (2) that additional info is needed in order to determine liability Upon receipt of additional info or upon administrative resolution where the insurer is deemed obligated to pay, insurer shall pay within 30/45 days of receipt	Any rate agreed upon in writing not in excess of 5% over the Federal Reserve discount rate Where there is no expressed contract rate, the legal rate of interest shall be 5% over the Federal Reserve discount rate	Under the Unfair Practices in the Insurance Business Act, willful violation could result in suspension or revocation of certificate of authority or license or an administrative fine in lieu thereof In addition, the Commissioner may order insurer to pay, the amount of claim plus interest	<i>This regulation does not create a cause of action for any person or entity, other than the Delaware Insurance Commissioner, against an insurer</i>
District of Columbia	Yes D.C. Code Ann. §§ 31-3131, 31-3132	Yes	No	30 days after receipt	Same	Notify within 30 days after receipt that claim is in dispute; state, in writing, the specific reasons for this finding; pay undisputed portion within 30 days of receipt; process disputed portion within 30 days after receipt of all reasonable & necessary documentation Physician has 180 days from the date of service to	The interest payable shall be at a monthly rate of (1) 1 ½ % from the 31 st - 60 th day; (2) 2% from 61 st - 120 th day; (3) 2 ½ % after 120 th day	The Insurance Commissioner determines if a health insurer has violated this Act; repeated violations can result in several penalties, including revocation of license or certificate of authority; civil penalty of up to \$1000 per violation	A claim is presumed to have been received 5 days after claim was mailed; 24 hours after e-claim submitted; or day the claim was delivered by courier Retroactive denials within 6 months of payment; must notify physician in writing as to the basis of retroactive denial

						submit a claim			Beginning with annual reports to Ins. Commission filed in March 2004, each insurer must report # of claims received, denied & paid in previous year and the average # of days to pay a claim in the previous year
State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Florida	Yes Fla. Stat. § 641.3155	No	Yes	40 days after receipt	20 days after receipt	For non-electronic submissions, the health insurer or HMO must: 1) notify provider within 40 days after receipt if it intends to contest/deny all/part; 2) itemized list of additional information needed to process (which must be returned within 35 days after receipt of notification); and 3) pay/ deny within 120 days after original receipt of claim; failure to pay/deny within 140 days after receipt creates an uncontestable obligation to pay For e-submissions, must: 1) notify provider within 20 days after receipt if it intends to contest/deny all/apart; 2) itemized list of additional information necessary to process (which must be returned within 35 days after receipt of notification); and 3) pay/deny within 90 days after receipt of the	12% per annum (begins to accrue when claim should have been paid/ denied/ contested)	Florida may issue cease and desist orders for cause 5% permissible error ratio; if error ratio exceed 5%, a fine may be assessed according to s. 624.4211* The department may fine a HMO for claims payment violations of paragraphs (3)(e) and (4)(e) which create an uncontestable obligation to pay the claim *§ 624.4211 provides for administrative fine in lieu of suspension or revocation	Prohibits automatic withholds or take-backs For all contracts entered into or renewed on or after 10-01-02, a HMO's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third party dispute entity must be finalized within 60 days after the receipt of the provider's request for review or appeal.

						claim; failure to pay/deny within 120 days after original receipt creates an uncontestable obligation to pay			
Georgia	Yes Ga. Code Ann. § 33-20A-6(b); 33-24-59.5	No	No	15 working days of receipt	Same	Insurer must: 1) Notify within 15 days of receipt; 2) state reasons for failure to pay; 3) itemize documents needed to process; 4) pay undisputed part of claim; 5) pay/deny claim within 15 working days of receiving necessary information	18% per annum	Penalties may be assessed under general insurance laws	Insurance Commissioner requires all insurers to file data on the speed of claims handling with their quarterly reports
Hawaii	Yes Haw. Rev. Stat. § 431:13-108; 431:13-201	Yes	No	30 days after receipt	15 days after receipt	Insurer must: 1) Notify within 15 days (7 days for electronic) if claim is contested/denied/ more time needed for review; 2) identify contested portion and reason for contesting/ denying claim and may request additional information; 3) pay within 30 days (15 days for electronic) after receiving information	15% per annum; In certain cases, ins. commissioner may suspend	Cease and desist orders re engaging in an unfair method of competition or unfair or deceptive act or practice Fine not more than \$1,000 for each act, not to exceed \$10,000 in any 6 month period – unless person knew or reasonably should have know, in which case \$5,000 - \$50,000 fine in any 6 month period Suspension or revocation of license	A first-party insured may bring a bad faith cause of action for insurer misconduct (administrative remedies not exclusive)
State	Prompt Pay Law	“Clean Claim” Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/ Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Idaho	No	--	--	--	--	--	--	--	--
Illinois	Yes	No	No	30 days after	Same	Insurer must notify of any	9% per year; from	Insurance Dept. may	Insurance Dept. shall

	Ill. Rev. Stat. ch. 215, para. 5/368a			receipt		known failure to provide sufficient documentation within 30 days after receipt	the 30 th day after receipt ; payments made within 30 days after payment	enforce the act pursuant to its general enforcement powers; may issue a cease and desist order, fine or otherwise penalize	adopt reasonable rules to enforce compliance with this Section
Indiana	Yes Ind. Code § 5-10-8.1 et seq., Ind. Code § 27-8-5.7 et seq. Ind. Code § 27-13-36.2 et seq.	Yes	No	45 days after receipt	30 days after receipt	Insurer/plan/administrator must notify of deficiency within 30/45 days of receipt and describe any remedy necessary to establish a clean claim. Failure to notify within timeframes establishes the claim as clean	As provided by law	Insurance Commissioner may impose graduated fines upon finding of non-compliance. Insurers may contest these penalties. Penalties are deposited in General Fund	--
Iowa	Yes Iowa Code §§ 507B et seq. (specifically §507B.4A)	Yes	No	Consistent with time frames and other procedural standards for claims decisions by group health plans established by US Department of Labor pursuant to 29 CFR pt. 2560 (in effect 01-01-02)	Same	Consistent with time frames and other procedural standards for claims decisions by group health plans established by US department of labor pursuant to 29 CFR pt. 2560 (in effect 01-01-02)	10% per annum	Insurance commissioner may issue cease and desist orders, suspend or revoke licenses and impose fines of up to \$1000 per violation, not to exceed an aggregate of \$10,000 – unless “knew or reasonably should have known”, then not more than \$5,000, not to exceed \$50,000 in the aggregate in one 6-month period	Insurance commissioner must adopt rules establishing processes for timely adjudication and payment If violate cease and desist order, the commissioner may issue (1) a monetary penalty of not more than \$10,000 for each act/violation and (2) suspension or revocation of such person’s license
Kansas	Yes Kan. Stat. Ann. §§ 40-2440 et seq.	Yes	No	30 days from receipt	Same	Send written or e-notice acknowledging receipt within 30 days; notice shall include date and shall indicate actual refusal to reimburse, provide specific reason(s) for denial OR state additional info necessary After receiving additional info (30 days after receipt of request to do so), insurer has 15 days after receipt to pay/deny	1% per month (on amount of claim that remains unpaid 30 days after receipt of claim)	Insurance commissioner may impose fines pursuant to the unfair and deceptive trade practices act in KSA 40-2401 et seq.	Insurance commissioner shall adopt rules and regulations necessary to carry out the provisions of the Kansas Health Care Prompt Payment Act

State	Ste	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Kentucky		Yes Ky. Rev. Stat. Ann. §§ 304.17A et seq.	Yes	Yes	30 days from receipt (except in claims involving organ transplants)* *Clean claims re organ transplants paid/denied/contested within 60 days from receipt	Same	If claim is submitted electronically, within 48 hours of receipt, insurer shall acknowledge receipt and notify re all information that is missing, errors, etc. that preclude claim from being "clean"; if claim is submitted in writing, insurer has 20 days from receipt to do the same Provider has 15 business days from date of receipt of notice to provide additional information Insurer to pay/deny within 30 days of receiving the additional information	12% per annum for claims paid 1-30 days late; 18% per annum for claims paid 31-60 days late; 21% per annum for claims paid more than 60 days late	Fines of up to \$1000 per day may be levied or 10% of the unpaid claim amount – whichever is greater; fines of up to \$10,000 may be imposed for willful and knowing violations or patterns of late payments	Insurers must: provide a mechanism for providers to check on claim status electronically; give 60 days notice to providers of material changes to provider manual relating to submission of claims info; recoup over-payments within 24 months from payment of the claim and notify providers if insurer recoups such over-payments by taking a deduction against future payment Limits retroactive denials to 24 months following payment Time frame for reporting of percentage of contested clean claims – based upon when claims were paid (rather than when adjudicated) Insurers must submit data on the # of claims paid within and after the proper timeframe, and indicate the # of days before ea. claim was fully adjudicated
Louisiana		Yes La. Rev. Stat. Ann. tit. 22, §§ 250.31 et seq.	No	Yes	45 days after receipt, if submitted within 45 days of the date of service; 60 days after receipt if submitted after 45 days	25 days after a correctly completed uniform claim form is transmitted	Issuer to provide written notice of reasons claim cannot be processed within 2 business days from the date of reviewing such claim	1% of amount due; for any period greater than 25 days following the time frames specified, an additional adjustment of 1% of unpaid balance due for ea. month or partial month	Cease and desist orders; monetary penalties (not more than \$1,000 for each act or violation, not to exceed \$100,000 in the aggregate – unless knew or reasonably should have – then, \$25,000 to no more than \$250,000); suspension/ revocation of certificate of authority	The commissioner may, after notice and hearing, promulgate rules and regulations to carry out the provisions of this Part Recoupment provisions

State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Maine	Yes Me. Rev. Stat. Ann. tit. 24-A, §§ 2436 et seq., § 4303 and § 4304	Defines "undisputed claim"	No	30 days after receipt (and ascertainment of the loss is made)	Same	Insurer must: 1) Notify claimant, in writing, within 30 days of receipt that additional info. is required; 2) pay within 30 days of receipt of such information If a claim is submitted using the health plans claim form and no response within 30 days, the claim is deemed to be "undisputed"	18% per annum (1.5% per month after due date)	May bring a civil action and recover damages, together with costs and disbursements, reasonable attorney's fees and interest on damages at the rate of 1 ½% per month	Insurer must give providers 90 days written notice of any amendments to provider contracts Insurers are allowed to seek refunds or partial refunds of previously paid claims within 90 days of submission Insurer is prohibited from changing procedural coding decisions made by providers
Maryland	Yes Md. Code Ann., Ins. §§ 15-1003 et seq. Md. Code Ann., Health § 15-102.3 Md. Regs. Code tit. 31, Subtitle 10, § 11 (applies to all claims recv'd on or after 9/7/2003)	Yes	Yes	30 days after receipt of claim	Same	Insurer has 30 days to send notice of refusal to reimburse; must include reason for refusal and state what information is necessary; must reimburse within 30 days after receipt of necessary info	1.5% per month if 31 to 60 days late; 2% per month if 61 to 120 days late; 2.5% per month if more than 120 days late	Fine not exceeding \$500 for each violation that is arbitrary and capricious, based on all available info and penalties prescribed under § 4-113(d)	Insurer may retroactively deny reimbursement up to 6 months after claim payment is made
Massachusetts	Yes Mass. Ann. Laws ch. 176G, §6	No	No	45 days after receipt	Same	Plan/insurer must notify claimant, in writing, of reasons for nonpayment and what additional info is necessary for reimbursement	1.5% per month (not to exceed 18% per annum)	--	--
State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Michigan	Yes Mich. Comp. Law § 500.2006	Yes	No	45 days after receipt	Same	Health plan shall (1) notify within 30 days after receipt of all known reasons that prevent claim from being a 'clean claim'; (2) provider has 45 days, and any additional time the health plan permits, after receipt of	12% per annum	In addition to any other penalty provided by law, the commissioner may impose a civil fine of not more than \$1,000 for each violation, not to exceed \$10,000 in	--

						notice to correct all known defects; (3) pay or deny within 45 days If claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be timely paid if paid within 60 days after receipt of form		the aggregate	
Minnesota	Yes Minn. Stat. § 62Q.75	Yes	No	30 days after receipt	Same	--	1.5% per month	Commissioner may not assess a financial administrative penalty against a plan for violation of the law	Plan must itemize interest payments made separately from other payments; plan may require provider to bill plan or TPA for interest
Mississippi	Yes Miss. Code Ann. § 83-9-5	Yes	No	35 days after receipt The insurer and provider may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as stringent as, the provisions set forth in state law – those provisions shall govern issues re timely payment	25 days after receipt	The insurer shall pay no later than 25 days (e-claim)/35 days (written claim) the appropriate benefit in full, or any portion of the claim that is clean and notify the provider of the reasons why the claim/portion is not clean and will not be paid and what substantiating documentation and information is required; the resubmitted claim shall be paid within 20 days after receipt	1-1/2% per month accruing from the day after payment was due	Person entitled to benefits may bring action to recover benefits, interest and any other damages allowable by law	If the Commissioner finds that an insurer, during any calendar year, has paid at least 85%, but less than 95% of all clean claims received, he/she may levy an aggregate penalty in an amount not to exceed \$10,000.00; has paid 50%, but less than 85% - not less than \$10,000 and no more than \$100,000.00; has paid less than 50%, not less than \$100,000 and no more than \$200,000
State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Missouri	Yes Mo. Rev. Stat. § 376.383	No	No	Within 10 days of receipt	Same	Within 10 days after receipt of claim, must acknowledge or send notice of status of the claim that includes a request for additional information; 15 days after	12% per annum	In addition to monthly interest due, pay claimant per day an amount of 50% of the claim, but not to exceed \$20 for failure to pay all or	--

						receipt of additional info, pay or send notice of receipt and status; 15 days after receiving additional info, in response to a final request, shall pay/deny		part of a claim or interest due thereon or deny or suspend as required by this section	
Montana	Yes Mont. Code Anno. §§ 33-18-231 through 33-18-235	No	No	30 days after receipt	Same	Insurer must pay/notify re the reasons for failure to pay in full and/or request additional information within 30 days of receipt of claim. If the insurer fails to do this, the insured/ assignee may report the delay to the Commissioner of Insurance. The Commissioner may investigate to determine if the insurer has failed to pay without good reason, and whether the delay is a general course of business practice	18% per annum (from date the commissioner finds the delay became unreasonable)	May not exceed \$1,000 for each separate violation. If insurer demonstrates it has consistently paid 90% of total amount outstanding in claims w/in 20 working days and all of the amount w/in 30 working days of receipt during the 6-month period preceding hearing date, not subject to fine imposed	--
Nebraska	No	--	--	--	--	--	--	--	--
Nevada	Yes Nev. Rev. Stat. § 683A.0879	No	No	30 days after receipt	Same	If additional info. is needed, insurer must notify within 20 days of receipt; notify of all specific reasons for delay; approve/deny within 30 days after receiving additional information	Prime rate at largest bank of Nevada, plus 6%	Court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section Commissioner may require evidence demonstrating substantial compliance with requirements set forth	Administrator shall not pay only part of a claim that has been approved and is fully payable
New Hampshire	Yes N.H. Rev Stat. Ann. §§ 415:18-k, 415:6-h	Yes	No	45 calendar days after receipt of clean claim	15 calendar days after receipt of a clean claim	If the insurer denies the claim, the insurer has 15 calendar days to notify the claimant of the reason for denying the claim and what, if any, additional information is required to process the claim	1.5% per month, beginning from the date the payment was due (insurer has 10 days after receipt of notice that claim is "overdue" to pay the claim – if insurer does not pay, then interest is assessed)	Upon a judicial finding of bad faith, provider may recover reasonable attorney's fees Commissioner may assess fines against insurers or may suspend or revoke the license or certificate upon finding of pattern of overdue payments and the action would not result in a deterioration of the	Does not apply to insurers in liquidation complying with a plan or rehabilitation. Providers have 90 days after the service was rendered to submit claims

State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
								financial condition of an at-risk insurer. Fines may be assessed up to \$5000 per violation, not to exceed \$100,000	
New Jersey	Yes N.J. Stat. Ann. §§ 17B:30-23, 17B:26-9.1, 17B:27-44.2, 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 26:2J-8.1	No	Yes	40 calendar days after receipt	30 calendar days after receipt OR time allowed under Medicare, whichever is shorter	Within 30 days, insurer to notify claimant, in writing or by electronic means, as appropriate, the following: 1) reason for denial; 2) if claim lacks required substantiating documentation, notify as to what info. is needed to complete adjudication of claim; 3) pay within 40 days (30 for electronic) of receipt of necessary info.	10% per annum	--	--
New Mexico	Yes N.M. Stat. Ann. § 59A-2-9.2	Yes	Yes	45 days after receipt	30 days after receipt	If plan is unable to determine liability for or refuses to pay a claim within specified timeframes, the plan must make a good faith effort to notify the participating provider within 30 days (45 for manual submission) of reasons for denial or specific information required to determine liability	1.5% per month	Superintendent may invoke aid of court to issue appropriate order to enjoin or enforce existing order Criminal prosecution – provide info to attorney general Enforce civil penalties under the Insurance Code	Prohibits contractual hold harmless agreements
New York	Yes N.Y. Ins. Law § 3224-a	No	Yes	45 days after receipt	Same	Where good faith dispute exists, insurer shall pay any undisputed portion of claim and notify, in writing, within 30 days of receipt: (1) that it is not obligated to pay the claim, stating the specific reasons why not; or (2) request all additional info needed. Upon receipt of info requested, insurer shall pay/ deny within 45 days	12% per annum or the rate set by the commissioner of taxation and finance for corporate taxes	Penalties under NY's Unfair Methods of Competition and Unfair and Deceptive Acts and Practices – civil penalty not to exceed \$500 per day, not to exceed \$10,000; if superintendent levies 5 separate civil penalties against one person in 5 years, additional civil penalty not to exceed \$50,000;	--

								another civil penalty not to exceed \$50,000 for every 5 subsequent violations within a 5 year period Also penalties under NY's Unfair Claim Settlement Practices Act	
State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
North Carolina	Yes N.C. Gen. Stat. § 58-3-225	No	No	30 days after receipt	Same	Insurer shall send notice of payment/denial/incomplete within 30 days after receipt; if claim is denied, notice shall include specific good faith reasons therefor; if proof is inadequate or incomplete, notice shall contain specific good faith reasons and an itemization or description of all info needed to complete processing; pay/ deny within 30 days after receiving additional info If denied or contested in part, insurer shall pay undisputed portion within 30 days after receipt, If not paid/denied within 60 days after receipt of initial claim, insurer to send claim status report – and again 30 days thereafter – if claim is still unresolved	18% per annum	In addition to or instead of suspending or revoking the license or certification, the Commissioner may order a monetary penalty or petition the court for an order directing payment of restitution; re a monetary penalty – shall not be less than \$100, nor more than \$1,000 The claimant can pursue any other action or remedy available under the law	--
North Dakota	Yes N.D. Cent. Code § 26.1-36-37.1	No	Yes	15 business days after receipt	Same	Insurer has 15 business days to pay part/all, deny or request additional info. Insured or assignee must be notified in writing that claim is contested and the reasons for the contest. Insurer must pay/deny within 15 business days of receipt of additional information	--	Willful violation is a class A misdemeanor Commissioner may suspend or revoke license of an insurer or insurance producer	--
Ohio	Yes	No	Yes	30 days after receipt	Same	If payor determines that supporting documentation	18% per annum, directly to the	Provider may file a written complaint	Most recent CPT code must be used; claim

	Ohio Rev. Code Ann. §§ 3901.38 et seq.					is needed, the payor must notify the provider within 30 days of receipt, stating, with specificity, what is needed.; provider can request that notification be made in writing.; payor must pay/ deny the claim within 45 days after receipt of additional information The time that elapses between a request and receipt of the documentation is not counted for purposes of determining compliance with the 45-day timeframe	provider	with the superintendent of insurance Superint. of insurance may require reports of compliance Superint. of insurance may impose admin. remedies if a consistent pattern or practice is determined: (1) Monetary penalties - \$100,000 re 1 st offense; \$150,000 re 2 nd offense occurring within 4 years of the 1 st ; \$300,000 re 3 rd /additional offense occur-ring within 7 years of the 1 st offense; (2) payment of interest directly to the provider; (3) cease and desist orders; (4) other admin. remedies	presumed received on 5 th business day after the claim was mailed/one business day after electronic submission; payment considered final after 2 years; providers may appeal "take back" request; providers may re-file claims under certain circumstances; payors may contract only for shorter timeframes than required by law
State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Oklahoma	Yes Okla. Stat. tit. 36, § 2514	Yes	No	45 calendar days after receipt of clean claim	Same	If a claim is determined to have defects/lack of required documentation, the insured/provider shall be notified in writing within 30 calendar days after receipt; notice must specify portion of the claim that is causing a delay and explanation of additional information/ corrections needed <i>Failure to do so the above amounts to a prima facie evidence that the claim will be paid according to terms of the policy</i> Upon receipt of additional info, insurers have 45	10% per year	Reasonable attorney's fees may be awarded by court and taxed as costs against the party(ies) who do not prevail	--

Oregon	Yes Or. Rev. Stat. § 743.866	Yes	No	30 days after receipt	Same	calendar days to pay/deny If additional information is needed, insurer must within 30 days after receipt notify the enrollee and provider in writing, explaining what additional information is needed. Insurer shall pay/deny the claim not later than 30 days after receipt of additional information	12% per annum	The Director of the Dept. of Consumer and Business Services may impose penalties or administrative actions under the OR Insurance Code	Each insurer shall report to the Director of the Dept. of Consumer and Business Services, annually, on its compliance under this law – according to requirements established by the director
Pennsylvania	Yes 40 Pa. Cons. Stat. § 991.2166	Yes	No	45 days after receipt of clean claim	Same	--	10% per annum	The Insurance Dept. or the Dept. of Health of the Commonwealth may impose a civil penalty of up to \$5,000 per violation A managed care plan is subject to the Unfair Insurance Practice Act Either department may issue an injunction to prohibit any activity that violates this act The Dept. of Health of the Commonwealth may issue an order temporarily prohibiting the plan from enrolling new members; also, require plan to develop and adhere to a plan of correction	In no event shall both departments impose a penalty for the same violation
State	Prompt Pay Law	“Clean Claim” Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Rhode Island	Yes R.I. Gen. Laws § 27-18-61	Each plan must establish standard defining what constitutes a “complete claim”	No	40 days after receipt	30 days after receipt	If claim is denied or pending, plan has 30 days from receipt to notify, in writing, the health care provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is	12% per annum	--	Providers must submit claims within 90 days after service is rendered unless submission is impossible due to matters beyond the control of the health care provider and were not caused by such health

						<p>required</p> <p>No health care entity or health plan may limit the time period in which additional information may be submitted to complete a claim</p> <p>A claim that is resubmitted shall be completed within 40 days following receipt (written) or 30 days (electronic)</p>			<p>care provider</p> <p>Health care entity or plan does not have to pay interest if the director of business regulation finds it in substantial compliance (processing and paying 95% or more of all claims within timeframes provided)</p>
South Carolina	No	--	--	--	--	--	--	--	--
South Dakota	<p>Yes</p> <p>S.D. Codified Laws Ann. § 5812-20</p>	Yes	Yes	45 calendar days after receipt	30 calendar days after receipt	<p>Claim shall be paid/denied/ settled within 30 days after receipt (electronic) or 45 days after receipt</p> <p>If additional info is required, within 30 days after receipt, carrier shall provide a full explanation of what additional info is necessary; provider to provide additional info within 30 days</p>	--	--	<p>Specifically states that no private right of action exists</p>

Tennessee	Yes Tenn. Code Ann. § 56-7-109 Tenn. Code Ann. § 56-32-226	Yes	No	30 days after receipt	21 days after receipt	Entities must, within 30/21 days of receipt: 1) Pay clean claims; 2) pay any portion of the claim that is not in dispute and notify the provider, in writing, why the remaining portion will not be paid; or 3) provide, in writing, reason why the claim is not clean and what information is necessary to process the claim No paper claim may be denied upon resubmission for lack of substantiating documentation or info that has been previously provided Health insurance entities shall timely provided contracted providers with all necessary info to properly submit a claim	1% per month	Commissioner of Commerce & Insurance shall ensure ongoing regulatory oversight – to ensure proper process and payment Commissioner may levy graduated fines: up to \$10,000 if an entity fails to properly handle 95% of all clean claims; up to \$100,000 for failure to properly handle 85% of all clean claims; and up to \$200,000 for failure to properly handle 60% of all clean claims Cease and desist orders may be issued; as well as proceedings to obtain injunctive relief in the chancery court Examinations to determine compliance may be conducted	Under § 56-32-226(b)(3)(A), the mere fact that a claim is not paid does not create a common substantive question of fact or law, unless the provider has received no remittance advice or other appropriate written or electronic notice from a health maintenance organization, either partially or totally denying a claim, within 60 days of the HMO's receipt of the claim and such claims regard a common substantive question of fact or law
State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Texas	Yes Tex. Ins. Code Ann. § 3.70-3C and §§ 843.000 et seq.* *§ 3.70-3C is entitled <i>Preferred Provider Benefits Plans</i> , while §§ 843.000 et seq. is entitled <i>Health Maintenance</i>	Yes	No	45 days after receipt	30 days after receipt	Within 45/30 days after receipt, insurer must: 1) pay the total amount of the claim; or 2) pay the portion of the claim not in dispute and notify the provider, in writing, why the remaining portion will not be paid; or 3) notify the provider, in writing, why the claim will not be paid		If a clean claim submitted to an insurer is payable and insurer fails to pay on or before the required date (as set forth in this statute), the insurer shall pay the provider making the claim the contracted rate owed on the claim plus a penalty in the amount of the lesser of (1) 50% of the difference between the billed charges or (2) \$100,000 If the claim is paid on	If the insurer acknowledges coverage but intends to audit the preferred provider claim, the insurer shall pay the charges submitted at 100% of the contracted rate not later than the 45/30 th day after receipt (to be indicated on the explanation of payment statement); if insurer requests additional info, must describe with specificity the clinical info requested and related only to info the insurer in good faith

	<i>Organizations</i>							<p>or after the 46th day and before the 91st day, the insurer shall pay a penalty in the amount of the lesser of (1) 100% of the difference between the billed charges, as submitted, and the contracted rate or (2) \$200,000</p> <p>If the claim is paid on or after the 91st day, the insurer shall pay a penalty computed according to statute plus 18% annual interest on that amount</p> <p>Penalties are also provided for where an insurer determines that a claim is payable and pays only a portion thereof on or before the required date (and pays the remainder after that date)</p> <p>In addition to the above, an insurer that violates this law in processing more than 2% of clean claims submitted to the insurer is subject to an administrative penalty (may not exceed \$1,000/day for each claim that remains unpaid)</p>	<p>can demonstrate is specific to claim or episode of care; may not request the patient's medical or billing record; audit must be completed within the 180th day after the clean claim is received by the insurer and any additional payment to provider (or refund to insurer) shall be made no later than the 30th day after to completion of the audit; insurer shall provide the provider with an opportunity to appeal (cannot recover payment until appeal rights are exhausted)</p> <p>Under § 3.70-3C, the insurer has no later than the 180th day after provider receives payment to recover an "overpayment" (must provide written notice re specific reasons for request of recovery of funds)</p> <p>A provider may recover reasonable attorney's fees and court costs in an action to recover payment.</p>
State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
Utah	Yes Utah Code Ann. § 31A-26-301.6	No	No	30 days after receipt	Same	Within 30 days, insurer must: 1) Provide written explanation if the claim is denied; 2) specifically describe and request additional info; 3) inform provider of the 30-day extension of the insurer's investigation; or request	<i>Can be agreed upon in a lawful contract between the parties; if not in contract, 10% per annum</i>	On or after 01-01-02, late fees imposed on insurer for failure to pay in timely manner and on the provider for failure to provide info timely	Insurer and provider have ability to include provisions in their contract that are more stringent than this Act Establishes definition of unfair claim settlement practices

						<p>additional info and inform provider of 30 day extension</p> <p>Provider shall provide additional info within 30 days of receipt – certain exceptions exist</p> <p>Extensions re insurer’s investigation are provided for; however, insurer shall pay and provide written explanation re a denial within 20 days of receiving info, or completing investigation</p>		<p>For first 90 days that claim payment/ provider response is late, a formula exists for determining the late fee (also exists if more than 91 days late)</p> <p>Commissioner may conduct examinations to determine level of compliance and impose sanctions for violations</p>	Each insurer shall establish a review process to resolve claims-related disputes – the commissioner may not adopt rules re this review process
Vermont	Yes Vt. Stat. Ann. tit. 18, § 9418	No	No	45 days after receipt	Same	<p>Within 45 days of receipt of claim, insurer must: 1) Notify claimant, in writing, that claim is contested/ denied; 2) include specific reasons and describe information necessary to process; 3) pay within 45 days after receipt of info</p>	<p>12% per annum (may be suspended by Commissioner in certain cases)</p>	<p>Commissioner may impose penalty, not to exceed \$500 per violation, if a pattern and practice of violations is established</p> <p>Commissioner may examine the books, accounts and papers; also, administer oaths and issue subpoenas to a person to appear and testify or produce documents, etc.</p>	<p>Individual contracts between provider and insurer may specify different time periods re payment</p> <p>Any dispute, at the option of either party, may be settled by arbitration</p>
Virginia	Yes Va. Code Ann. § 38.2-3407.15	Yes	No	40 days after receipt	Same	<p>Carrier has 30 days after receipt to request info. and documentation necessary to process and pay claim or determine if claim is clean</p>	As established by law	<p>Provider entitled to initiate an action to recover actual damages; if trier of fact finds in favor of provider, due to carrier’s gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained</p> <p>Provider may be</p>	<p>Retroactive denials permitted, with restrictions</p> <p>Commission not “trier of fact”</p> <p>Commission may promulgate rules and regs to implement this section</p> <p>Commission has no jurisdiction to adjudicate individual controversies arising out of this section</p>

State	Prompt Pay Law	"Clean Claim" Defined	Uniform Claim Form	Timeframe: Non-Electronic	Timeframe: Electronic	Notice/Timeframe for Incomplete/Contested Claim	Interest Incurred	Enforcement and Penalties	Other
								awarded reasonable attorney's fees and court costs Each claim for payment constitutes a separate violation	
Washington	Yes (reg.) Wash. Admin. Code § 284-43-321	Yes	No	95% of the monthly volume of clean claims must be paid within 30 days of receipt; 95% of the monthly volume of all claims must be paid or denied within 60 days of receipt (except as agreed to in writing by the parties)	Same	Denial must include specific reason why the claim was denied in cases of denials based on medical necessity, the carrier must disclose the basis for the decision	1% per month – simple interest prorated for any portion of a month	As per contract entered into by relevant parties	Every participating provider and facility contract shall set forth a schedule for the prompt payment of amounts owed by the carrier to the provider and shall include penalties for failure to abide by that schedule; at a minimum, these contracts shall conform to the standards of this section
West Virginia	Yes W. Va. Code § 33-45-2	Yes	No	40 days after receipt	30 days after receipt	Insurer shall, within 30 days after receipt, request additional info required to process and pay the claim or to determine if claim is clean; if necessary, within 15 days of receipt of additional info, insurer may ask for additional info (insurer has only this one extra time to do so) ; pay/ deny within 30 days of receipt	10% per annum	Initiate action to recover actual damages Provider or insurer not precluded to pursue other administrative, civil or criminal proceedings or remedies	Retroactive denials are not precluded Commissioner shall not be deemed to be a "trier of fact" re actions to recover actual damages Commissioner authorized to propose rules for legislative approval (to implement provisions of this article)
Wisconsin	Yes Wis. Stat. § 628.46	No	No	30 days after receipt	Same	Partial payments to be made within 30 days of receipt; remainder of claim is overdue if not paid within 30 days after written notice is furnished	12% per annum	--	Provision for payment of chiropractic services is included
Wyoming	Yes Wyo. Stat. § 26-15-124	No	Yes	45 days after receipt	Same	Claims rejected or accepted and paid within 45 days of receipt; exceptions to the 45-day rule shall be made if there is any question as to the validity or amount of the	--	If refusal to pay is determined to be unreasonable or without cause, any court in which judgment is rendered may also award a	If there is a question as to the validity or the amount of the claim, the question is referred to the Wyoming state medical peer review

						claim		reasonable sum as an attorney's fee and interest at 10% per year	committee for adjudication Provides for venue of suits against insurers
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TAB 3

GEORGIA

Display Text By Bill Number

Page 1 of 4

STATE and FEDERAL LEGISLATION || STATE and FEDERAL REGULATIONS NEWS / REFERENCE

STATE

MESSAGE OF THE DAY SITE INDEX HOME BACK

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In bill text, brackets have special meaning:

[A> <A] contains added
text, and
[D> <D] contains deleted
text.

Georgia 145th General Assembly -- 1999-00 Regular
Session
1999 GA H 159
Enacted
04/19/1999
Graves
HB 159 HB
159/AP
H. B. No. 159 (AS PASSED HOUSE AND SENATE)

By: Representatives Graves of the 125th, Williams of the 83rd, Bannister
of the 77th, Jones of the 71st,
Tolbert of the 25th and others

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating
to insurance, so as to provide for confidentiality of patients' medical
information obtained by health insurers from pharmacies or pharmacists;
to prohibit release of certain information to third parties without

patient consent; to define a term; to provide a penalty for violations; to provide for time limits for payment of claims under certain health benefit plans and provide for sanctions; to change certain provisions relating to required policy provisions for individual accident and sickness insurance; to provide for notice prior to certain premium increases; change certain provisions relating to required provisions of group accident and sickness insurance policies; to provide for applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new Code Section 33-24-59.4 to read as follows:

"33-24-59.4.

(a) As used in this Code section, the term 'insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45; and such term includes any entity which administrates or processes claims on behalf of any of the foregoing.

(b) Any medical information concerning a patient that was obtained by or released to an insurer from a pharmacy or pharmacist shall be confidential and privileged and may be released by such insurer to a third party for consideration only if such release is specifically authorized by such patient or a person otherwise authorized to act therefor. Any insurer possessing patient medical information which was obtained from a pharmacy or pharmacist shall not release such information to any third party for consideration without the explicit written consent of the patient or a person otherwise authorized to act therefore, which consent was obtained after written notice by the insurer to such patient or person otherwise authorized to act therefore of the purpose of such release, the party or parties to whom the information will be released, and any consideration paid or to be paid to the insurer for such information.

(c) The provisions of subsection (b) of this Code section shall not prohibit the release of medical information by an insurer to a third party for purposes of appropriate medical research without notice to or the written consent of a patient or person authorized to act therefore, provided that such release does not provide any information that identifies a patient, prescriber, pharmacy, or pharmacist, including without limitation any name, address, or telephone number of a patient, prescriber, pharmacy, or pharmacist. Information released in accordance with the provisions of this subsection may be used for appropriate medical research.

(d) Violation of this Code section by any insurer to which any license or certificate of authority has been issued under this title shall constitute an unfair trade practice punishable under Article 1 of Chapter 6 of this title."

SECTION 2.

Said title is further amended by adding a new Code Section 33-24-59.5 to read as follows:

"33-24-59.5.

(a) As used in this Code section, the term:

(1) 'Benefits' means the coverages provided by a health benefit plan for financing or delivery of health care goods or services; but such term does not include capitated payment arrangements under managed care plans.

(2) 'Health benefit plan' means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy, or managed care plan; but health benefit plan does not include policies issued in accordance with Chapter 31 of this title; disability income policies; or Chapter 9 of Title 34, relating to workers' compensation.

(3) 'Insurer' means an accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(b) (1) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer's receipt of written proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days after such receipt mail to the insured or other person claiming payments under the plan payment for such benefits or a letter or notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim have been received by the insurer, the insurer shall then have 15 working days within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the insured or other person claiming payments under the plan the insurer's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administrates or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to 18 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section."

SECTION 3.

Said title is further amended by striking paragraph (8) of subsection (b) of Code Section 33-29-3, relating to required policy provisions for individual accident and sickness insurance, and inserting in lieu thereof the following:

"(8) Time of payment of claims. [A> The policy shall include a provision incorporating and restating the substance of the provisions of subsections (b) and (c) of Code Section 33-24-59.5, relating to time limits for payment of claims for benefits under health benefit policies and sanctions for failure to pay timely. <A]

[D> (A) All benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss. Should the insurer fail to pay the benefits payable under its policy, other than benefits payable for loss of time, upon receipt of due written proof of loss, the insurer shall have 15 working days thereafter within which to mail the insured or subscriber a letter or notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the insured or subscriber a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, the insurer shall then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving the insured the reasons the insurer may have for denying such claim or any portion thereof. (B) Subject <D] [A> If a policy provides benefits for loss of time, such policy shall also provide that, subject <A] to proof of [A> such <A] loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the insurer is liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

[D> (C) Each insurer admitted to transact accident and sickness insurance in this state shall pay interest to the insured equal to 18 percent per annum on the proceeds or benefits due under the terms of the policy for failure to comply with the requirements of subparagraph (A) or (B) of this paragraph.
<D] "

SECTION 4.

Chapter 29 of Title 33 of the Official Code of Georgia Annotated, relating to individual accident and sickness insurance, is amended by adding at the end a new Code section to read as follows:

"33-29-22.

Notice of any premium increase shall be mailed or delivered to each holder of an individual accident and sickness insurance policy not less than 60 days prior to the effective date of such increase."

SECTION 5.

Said title is further amended by striking paragraph (5) of subsection (b) of Code Section 33-30-6, relating to required provisions of group accident and sickness insurance policies, and inserting in lieu thereof the following:

"(5) [D> (A) <D] A provision [A> incorporating and restating the substance of the provisions of subsections (b) and (c) of Code Section 33-24-59.5, relating to time limits for payment of claims for benefits under health benefit policies and sanctions for failure to pay timely <A] [D> that all benefits payable under the policy other than benefits for loss of

time will be payable immediately upon receipt of due written proof of such loss. Should the insurer fail to pay the benefits payable under the policy, other than benefits for loss of time, upon receipt of due written proof of loss, the insurer shall have 15 working days thereafter within which to mail the insured or subscriber a letter or notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the insured or subscriber a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, the insurer shall then have 15 working days within which to process and either pay the claim or deny it, in whole or in part, giving the insured the reasons the insurer may have for denying such claim or any portion thereof <D] .

[D> (B) Subject <D] [A> If a policy provides benefits for loss of time, such policy shall also provide that, subject <A] to proof of [A> such <A] loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the insurer is liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

[D> (C) Each insurer admitted to transact accident and sickness insurance in this state shall pay interest to the insured equal to 18 percent per annum on the proceeds or benefits due under the terms of the policy for failure to comply with the requirements of subparagraph (A) or (B) of this paragraph. <D] "

SECTION 6.

Sections 2, 3, and 4 of this Act shall apply to plans, policies, or contracts issued, delivered, issued for delivery, or renewed on or after the date this Act becomes effective.

SECTION 7.

All laws and parts of laws in conflict with this Act are repealed.

<http://client.statenet.com/secure/pe/onebill.egi>

11/1/99

MARYLAND

SENATE BILL 465

By: **Senator Teitelbaum**
Introduced and read first time.
January 30, 1997
Assigned to: Finance

Committee Report: Favorable with
amendments
Senate action: Adopted
Read second time: February 25, 1997

CHAPTER

AN ACT concerning

Health Insurance - Reimbursement of Service Providers

FOR the purpose of ~~providing that any time limit for submitting claim information imposed by an insurer, nonprofit health service plan, or health maintenance organization on certain providers of health care services does not begin to run until the insurer, nonprofit health service plan or health maintenance organization gives a certain notice to the provider of the health care service requiring a health maintenance organization, insurer, or nonprofit health service plan to permit a provider a minimum of 6 months to submit a clam for reimbursement: requiring a health maintenance organization, insurer, or nonprofit health service plan to reimburse a provider within a certain time. under certain circumstances. after receiving certain documentation;~~ and generally relating to re:.- t reimbursement of health care *service* providers.

BY repealing and reenacting, with amendments.

Article - Health - General
Section 19-712.1
Annotated Code of Maryland
(1996 Replacement Volume and 1996 Supplement)

BY repealing and reenacting, * with amendments.

Article - Insurance
Section 15-1005
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter - (H.B. 11) of the Acts of the General Assembly of 1997)

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.

[Brackets] indicate matter deleted from existing law.

Underlining indicates amendments to bill.

Strikeout indicates matter stricken from the bill by amendment or deleted from the law by amendment.

2

SENATE BILL 465

1

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF 2

2

MARYLAND, That the Laws of Maryland read as follows:

3

Article - Health - General 4 19-712.1.

5

(a) For covered services rendered to its members, a health maintenance t,
6 organization shall reimburse any provider within 30 days after receipt of a claim that is
7 7 accompanied by all reasonable and necessary documentation.

8

(b) (1) If a health maintenance organization fails to comply with subsection (a)

9

of this section. the health maintenance organization shall pay interest beginning with the
10 31st day on the amount of the claim that remains unpaid after 30 days following the
11 receipt of the claim.

12

(2) The interest payable shall be at the rate of 1.5 percent per month simple

13

13 interest prorated for any portion of a month.

14

(3) Except as provided in subsection (c) of this section, when paying a claim 15

15

more than 30 days after its receipt, the health maintenance organization shall add the

16

interest payable to the amount of the unpaid claim without the necessity for any claim for

17

that interest to be made by the provider filing the original claim.

18

(c) The provisions of this section do not apply to claims where:

19

(1) There is a good faith dispute regarding:

20

(i) The legitimacy of the claim; or

21

(ii) The appropriate amount of reimbursement; and

22

(2) The health maintenance organization:

23

(i) Notifies the provider within 2 weeks of the receipt of the claim that

24

the legitimacy of the claim OR the appropriate amount of reimbursement is in dispute;

25

(ii) Supplies in writing to the provider the specific reasons why the

26

legitimacy of the claim, or a portion of the claim, or the appropriate amount of

27

reimbursement is in dispute;

28

(iii) Pays any undisputed portion of the claim within 30 days of the 2

29

receipt of the claim; and

30

(iv) Makes a good faith, timely effort to resolve the dispute.

31

~~(D) IF A HEALTH MAINTENANCE ORGANIZATION SENDS NOTICE TO A~~

32

~~PROVIDER UNDER SUBSECTION (C)(2)(I) OR (II) (II) OF THIS SECTION, OR NOTIFIES A~~

33

~~PROVIDER THAT IT DID NOT RECEIVE A CLAIM< ANT TIME LIMIT IMPOSED BY THE~~

34

~~HEALTH MAINTENANCE ORGAINIZATION FOR SUBMITTING CLAIM INFORMATION~~

35

~~SHALL BEGIN ON THE DATE THE NOTICE IS GIVEN~~

36 **(D) A HEALTH MAINTENANCE ORGANIZATION SHALL PERMIT A PROVIDER A**
37 **MINIMUM OF 6 MONTHS FROM THE DATE A COVERED SERVICE IS RENDERED TO**
38 **SUBMIT A CLAIM FOR REIMBURSEMENT FOR THE SERVICE.**

SENATE BILL 465

1 (E) (1) IF A HEALTH MAINTENANCE ORGANIZATION NOTIFIES A PROVIDER
2 THAT ADDITIONAL DOCUMENTATION IS NECESSARY TO ADJUDICATE A CLAIM. THE
3 HEALTH MAINTENANCE ORGANIZATION SHALL REIMBURSE THE PROVIDER FOR
4 COVERED SERVICES WITHIN 30 DAYS AFTER RECEIPT OF ALL REASONABLE AND
5 NECESSARY DOCUMENTATION.
6 (2) IF A HEALTH MAINTENANCE ORGANIZATION FAILS TO COMPLY
7 WITH THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION, THE HEALTH
8 MAINTENANCE ORGANIZATION SHALL PAY INTEREST IN ACCORDANCE WITH THE
9 REQUIREMENTS OF SUBSECTION (8) OF THIS SECTION.

Article - Insurance

11 15-1005.

12 (a) This section does not apply when there is a good faith dispute about the
13 legitimacy of a claim or the appropriate amount of reimbursement.
14 (b) To the extent consistent with the Employee Retirement Income Security Act
15 of 1974 (ERISA), 29 U.S.C. 1001, et seq., this section applies to an insurer or nonprofit
16 health service plan that acts as a third party administrator.
17 (c) Within 30 days after receipt of a claim for reimbursement from a person
18 entitled to reimbursement under § 15-701(a) of this title or from a hospital or related
19 institution, as those terms are defined in § 19--301 of the Health - General Article. an
20 insurer or nonprofit health service plan shall:
21 (1) pay the claim in accordance with this section; or
22 (2) send a notice of receipt and status of the claim that states:
23 (i) that the insurer or nonprofit health service plan refuses to
24 reimburse all or part of the claim and the reason for the refusal; or
25 (ii) that additional information is necessary to determine if all or part
26 of the claim will be reimbursed and what specific additional information is necessary.

27 ~~— (D) IF AN INSURER OR NONPROFIT HEALTH SERVICE PLAN SENDS NOTICE~~
28 ~~UNDER SUBSECTION (C) (2) OF THIS SECTION, OR NOTIFIES THE PERSON THAT~~
29 ~~FILED A CLAIM THAT THE CLAIM WAS NOT RECEIVED, ANY TIME LIMIT IMPOSED BY THE~~
30 ~~INSURER OR NONPROFIT HEALTH SERVICE PLAN FOR SUBMITTING CLAIM~~
31 ~~INFORMATION SHALL BEGIN ON THE DATE THE NOTICE IS GIVEN.~~

32 (D) AN INSURER OR A NONPROFIT HEALTH SERVICE PLAN SHALL PERMIT A
33 PROVIDER A MINIMUM OF 6 MONTHS FROM THE DATE A COVERED SERVICE IS
34 RENDERED TO SUBMIT A CLAIM FOR REIMBURSEMENT FOR THE SERVICE.

35 (E) (1) IF AN INSURER OR NONPROFIT HEALTH SERVICE PLAN NOTIFIES A
36 PROVIDER THAT ADDITIONAL DOCUMENTATION IS NECESSARY TO ADJUDICATE A
37 CLAIM, THE INSURER OR NONPROFIT HEALTH SERVICE PLAN SHALL REIMBURSE

SENATE BILL 465

1 (2) IF AN INSURER OR NONPROFIT HEALTH SERVICE PLAN FAILS TO
2 COMPLY WITH THE REQUIREMENTS OF PARAGRAPH. (I) OF THIS SUBSECTION, THE
3 INSURER OR NONPROFIT HEALTH SERVICE PLAN SHALL PAY INTEREST IN
4 ACCORDANCE WITH THE REQUIREMENTS OF SUBSECTION (F) OF THIS SECTION.

5 [(d)] ~~(E)~~ (E) (1) If an insurer or nonprofit health service plan fails to comply
6 with subsection (c) of this section, the insurer or nonprofit health service plan shall pay
7 interest on the amount of the claim that remains unpaid 30 days after the claim is filed at
8 the monthly rate of;

9 (i) 1.5% from the 31st day through the 60th day;

10 (ii) 2% from the 61st day through the 120th day; and

11 (iii) 2.5% after the 120th day.

12 (2) The interest paid under this subsection shall be included in any late
13 reimbursement without the necessity for the person that filed the original claim to make
14 an additional claim for that interest.

15 SECTION 2. AND BE *IT FURTHER* ENACTED. That this Act shall take effect
16 October 1, 1997.

Approved:

Governor

President of the Senate.

Speaker of the House of Delegates.

TENNESSEE

CHAPTER NO. 890

HOUSE BILL NO. 1192

By Representatives Kisber, Caldwell, Lewis, Windle, Sherry Jones, Ferguson, Curtiss, Givens, Maddox, Sands, Fitzhugh, White, Walker

Substituted for: Senate Bill No. 1573

By Senators Cooper, Kyle, Cohen, Person, McNally, Crutchfield, Haun, Crowe, Davis, Graves

AN ACT to amend Tennessee Code Annotated, Title 56; and Title 71, Chapter 5, to establish procedures ensuring the prompt payment of provider claims submitted to health maintenance organizations, health insurers, nonprofit health service plans, managed care organizations, managed health insurance issuers, and behavioral health organizations, including any entity reimbursing the cost of health care services.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. The title of this act is and may be cited as the "Timely Reimbursement of Health Insurance Claims Act." The purpose of this act is to ensure the prompt and accurate payment of all provider claims for covered services delivered to eligible health insured patients. The General Assembly further intends that this act provide direct provider rights to prompt payment under Section 68-11-219, which requires a patient's assignment of a claim. Nothing in this act will require a health insurance entity to pay claims that are not covered under a health insurer entity's contract.

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 1, is amended by adding the following new, appropriately designated section:

Tennessee Code Annotated 56-7-_. (a) As used in this section:

(1)(A) "Clean claim" means a claim received by a health insurance entity for adjudication, and which requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health insurer. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this act.

(B) A clean claim does not include a duplicate claim. A duplicate claim means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim.

(C) A clean claim does not include any claim submitted more than ninety (90) days after the date of service.

(D) The definition of clean claim includes resubmitted paper claims with previously identified deficiencies corrected.

(2) "Health insurance entities" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation.

(3) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate or agreement offered by a health insurance entity; provided, however, that health insurance coverage does not include policies or certificates covering only accident, credit, disability income, long-term care, hospital indemnity, Medicare supplement as defined in § 1882(g)(1) of the Social Security Act, specified disease, other limited benefit health insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) "Pay" means that the health insurance entity shall either send the provider cash or a cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health insurance entity. Payment shall occur on the date when the cash, cash equivalent or notice of credit is mailed or otherwise sent to the provider.

(5) "Submitted" means that the provider either mails or otherwise sends a claim to the health insurance entity. Submission shall occur on the date the claim is mailed or otherwise sent to the health insurance entity.

(b) Prompt Payment Standards.

(1)(A) Not later than thirty (30) calendar days after the date that a health insurance entity actually receives a claim submitted on paper from a provider, a health insurance entity shall:

(i) if the claim is clean, pay the total covered amount of the claim;

(ii) pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid; or

(iii) notify the provider in writing of all reasons why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean.

(B) Not later than twenty-one (21) calendar days after receiving a claim by electronic submission, a health insurance entity shall:

(i) if the claim is clean, pay the total covered amount of the claim;

(ii) pay the portion of the claim that is clean and not in dispute and notify the provider why the remaining portion of the claim will not be paid; or

(iii) notify the provider of the reason why the claim is not clean and will not be paid and what substantiating documentation or information is required to adjudicate the claim.

(2) No paper claim may be denied upon resubmission for lack of substantiating documentation or information that has been previously provided by the health care provider.

(3) Health insurance entities shall timely provide contracted providers with all necessary information to properly submit a claim.

(4) Any health insurance entity that does not comply with subdivision (b)(1) shall pay one percent (1.0%) interest per month, accruing from the day after the payment was due, on that amount of the claim that remains unpaid

(c) Regulatory Oversight.

(1) The Commissioner of the Department of Commerce and Insurance shall ensure, as part of the department's ongoing regulatory oversight of health insurance entities, that health insurance entities properly process and pay claims in accordance with the "Timely Reimbursement of Health Insurance Claims Act".

(2) If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay ninety-five percent (95%) of all clean claims received from all providers during that year in accordance with this act, the commissioner may levy an aggregate penalty up to ten thousand dollars (\$10,000). If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay eighty-five percent (85%) of all clean claims received from all providers during that year in accordance with this Act, the commissioner may levy an aggregate penalty in an amount not less than ten thousand dollars (\$10,000) nor more than one hundred thousand dollars (\$100,000), if reasonable notice in writing is given of the intent to levy the penalty. If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay sixty percent (60%) of all clean claims received from all providers during that year in accordance with this act, the commissioner may levy an aggregate penalty in an amount not less than one hundred thousand dollars (\$100,000) nor more than two hundred thousand dollars (\$200,000). In determining the amount of any fine, the commissioner shall take into account whether the failure to achieve the standards in this act is due to circumstances

beyond the health insurance entities' control and whether the health insurance entity has been in the business of processing claims for two (2) years or less. The health insurance entity may request an administrative hearing contesting the assessment of any administrative penalty imposed by the commissioner within thirty (30) days after receipt of the notice of the assessment.

(3) The commissioner may issue an order directing a health insurance entity or a representative of a health insurance entity to cease and desist from engaging in any act or practice in violation of this act. Within fifteen (15) days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this act have occurred.

(4) All hearings under this part shall be conducted pursuant to Tennessee's Uniform Administrative Procedures Act.

(5) In the case of any violations of this act, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued by the commissioner, the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the Chancery Court of Davidson County.

(6) Examinations to determine compliance with this Act may be conducted by the commissioner's staff. The commissioner may, if necessary, contract with qualified impartial outside sources to assist in examinations to determine compliance with this act. The expenses of any such examinations shall be assessed against Health Maintenance Organizations in accordance with TCA 56-32-215. For other health insurance entities, the commissioner shall bill the expenses of such examinations to those entities in accordance with T.C.A. §56-1-413.

(d) The commissioner shall adopt rules and regulations to ensure effective compliance with this act.

SECTION 3. Nothing in this act will require a health insurance entity to pay claims that are not covered under the terms of a health insurer entity's contract. This provision does not prevent a claim of an out of network provider from being a clean claim.

SECTION 4. Nothing contained herein shall be construed or interpreted as applying to the TennCare programs under Title XIX of the Social Security Act or any successor to the TennCare program administered pursuant to the federal Medicaid laws.

SECTION 5. This act shall not preclude the right of a claimant to pursue any other administrative, civil or criminal proceedings or remedies permitted under state or federal law. This act shall also not preclude the Commissioner of the Department of Commerce and Insurance from pursuing any other administrative, civil or criminal proceedings or remedies permitted under state or federal law, except the commissioner may not impose any monetary penalties greater than those set forth in this act against health insurance entities found in violation of this act.

SECTION 6. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 7. This act shall take effect November 1, 2000, the public welfare requiring it and shall apply to all outstanding clean claims to which this act applies that remain unreimbursed sixty (60) days after the date this act takes effect.

PASSED: May 31, 2000


JIMMY NAIFEH, SPEAKER
HOUSE OF REPRESENTATIVES

JOHN S. WILDER, SPEAKER OF
THE SENATE

APPROVED this 4th day of June

2000


DON SPANG, GOVERNOR

American Medical Association, Advocacy Resource Center
August 2000

**Advocacy Resource Center
Campaign to Promote Timely Payment**

LEGISLATIVE TEMPLATE

This template provides an overview of the various potential elements of legislation and/or regulations to address late payment by health carriers.

I. REQUIREMENTS REGARDING TIMELY PAYMENT

A. Application

1. General

The legislation should cover all health carriers in the states, including insurers, HMOs, PPOs, PSOs, and any other form of third-party payor. Over the past few years, several states have enacted legislation that creates a statutory penalty for third party payors that fail to pay claims within a specified time frame. Historically, many states had some form of penalty provision that applied to health insurers, but these provisions typically did not apply to HMOs and other types of managed care organizations.

2. Application to sub-contractors

The language should include a statement that the requirements apply to all entities that pay or administer claims on behalf of a health carrier. This calls into question whether states can regulate this aspect of the payment processes of an entity that administers payment of benefits for a self-insured plan. This has not been tested in the courts, but we believe that recent developments in ERISA case law suggest that this type of regulation may be applied to administrators for self-

insured plans if the regulation provides a reasonable amount of time for payment (so as to avoid an argument by plans that the law interferes with the administration of health plan benefits and should be preempted). The Supreme Court has recognized a general right of creditors to bring state law claims against ERISA plans that fail to pay bills. See, Mackey v. Lanier Collection Agency & Service, 486 U.S. 825 (1988).

3. Examples of Legislative Language:

North Dakota Regulation Section 45-06-03.1-01 states: "*Issuer*" means an insurance company, fraternal benefit society, health care service plan, health maintenance organization, or their party administrator, or any entity reimbursing the costs of health care services. (Regulation implements timely payment statute).

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Missouri's law provides that: *To the extent consistent with the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S. C. 1001 et seq., this section shall apply to any health insurer... , nonprofit health service plan and any health maintenance organization. Sect. 376.383 R S. Mo.*

Illinois' law applies to "*insurers, health maintenance organizations, managed care plans, health care plans, preferred provider organizations, third party administrators, independent practice associations, and physician-hospital organizations ... that provider periodic payments...*" to providers. 215 ILCS 5/356y.

B. Amount of Time Allowed Between Claim Submission and Payment

The amount of time that states give health carriers to pay claims varies a great deal. AMA Model legislation calls for electronic claims to be paid within 14 days and written claims to be paid within 30 days. In 1999, states began to reflect this policy of requiring shorter turnaround times for electronic claims.

States vary in the amount of time provided before payment of claims is considered delinquent as follows: 15 days (Georgia, Hawaii (electronic claims), North Dakota, Virginia, West Virginia), 24 days (Ohio), 25 days (Alabama), 30 days (Alaska, Arizona, California, Hawaii (paper claims), Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Montana, Nevada, Oklahoma, Vermont, Wisconsin), 35 days (Florida), 40 days (Virginia), 45 days (Colorado, Connecticut, Delaware, Mississippi, Missouri, New York, Texas, Wyoming) and 60 days (Michigan - specifies that penalties accrue after 60 days, although claim is technically "late" after 30 days, Nevada, New Jersey, Tennessee).

For electronic claims, Hawaii law specifies such claims are to be paid within 15 days of receipt. Tennessee requires such payment within 21 days of receipt, while Colorado and New Mexico require payment within 30 days. New Jersey requires payment within 30 days or within the time allowed under Medicare, whichever is shorter.

Louisiana takes an interesting tact of tying the time required for payment to whether the provider submitted the claim within 45 days after the date the service was provided / the patient was discharged. For claims submitted within the 45 days, payment is required within 45 days (25 days for electronically submitted claims). If a claim is submitted 45 or more days after services are provided, payment is required within 60 days of receipt.

C. Time for Paying Resubmitted Claims.

Some states have specified a shorter time period (i.e., 10 days in Missouri) in which the payor must pay a corrected, properly resubmitted claim that was initially rejected by the plan for some deficiency.

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D. Penalties

1. Interest

Interest is typically assessed at a statutorily specified rate on unpaid claims that have not been contested or remain unpaid without good cause. The level of interest is assessed at either a per month or per annum basis. It should be specified that the third party payer's obligation to pay the penalty is automatic, and should not require any action by the provider.

When assessed on a per month basis, the interest assessed by states is typically 1 1/2% per month (Alabama, Maine, Mississippi); Louisiana charges a 1% per month penalty. When assessed on a per annum basis, states require from 8% (Virginia) to 18% (Georgia, Montana, Texas). Several states charge 12% (Kentucky, Michigan, New York, Wisconsin) or 15% (Connecticut), while others charge a lesser amount (Illinois charges 9%; California, Colorado, Florida, New Jersey, Wisconsin, Wyoming charge 10%).

Maryland imposes a graduated interest rate based on how delinquent the payment becomes, as follows: 1.5% from the 31st day through the 60th day; 2% from the 61st day through the 120th day; and 2.5% after the 120th day. Likewise, Kentucky assesses an interest penalty of 12% per annum for delinquent claims from the 30th through the 60th day; 18% from the 61st day through the 90th day; and 21 % after the 90th day.

Some states provide for a cap on the maximum penalty, ranging from the amount of the policy limits (Michigan) to 25% of the amount of the unpaid.

2. Additional Penalties

A number of state laws allow for the imposition of fines in addition to interest payments due on delinquent claims. New York's statute grants the Superintendent of Insurance the authority to impose a \$500 per day fine in addition to interest penalties. In Arkansas, the Insurance Department may fine carriers up to \$100 per violation, not to exceed \$10,000. If a pattern is established,

carriers may be fined up to \$5000 per violation, not to exceed \$50,000. Tennessee bases the amount of the fine on the number of claims that are delinquent in a given time period (up to \$10,000 if an entity fails to properly handle 95% of clean claims; up to \$100,000 for failure to properly handle 85% of such claims, etc..)

It is wise to impose an additional penalty for payers that fail to pay claims in accordance with state requirements for an extended period of time. For instance, Colorado's law imposes a penalty of 3% of the total amount for claims that are unpaid 90 days after being submitted, with payment of the penalty / claim due on the 91st day. Virginia's Fair Claims Practice Act allows for an action to recover actual damages emanating from a violation of the Act, and for up to 3x the actual damages sustained if a trier of fact finds that violation of the act was due to gross negligence and willful conduct.

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3. Payment to the Patient / Insured

Missouri's law requires that the provider who is paid interest shall pay the proportionate amount of interest to a patient / insured to the extent and for the time period that the patient / insured had paid for the services and for which reimbursement was due to the patient / insurer.

4. Attorneys' Fees

States should allow for reasonable attorneys' fees and costs for a claimant's successful effort to recoup unpaid claims. Laws in Maine, Tennessee and Kentucky allow for such recovery.

5. Examples of Legislative Language

Kentucky law provides: *"When paying a claim after the time required [by this Act], the insurer shall add the interest payable to the amount of the unpaid claim without the necessity for any claim for that interest to be made by the provider filing the original claim ... In addition to any other penalty or remedy authorized by law, the department may assess the following fines... one thousand dollars per day or ten percent of the unpaid claim amount, whichever is greater, for each day that a clean claim remains unpaid... a fine of up to ten thousand dollars where the commissioner determines that an insurer has willfully and knowingly violated... this Act or has a pattern of repeated violations... of this Act. " 2000 KY SB 279.*

Vermont law provides: *"If the Commissioner finds, after notice and hearing, that a health plan has violated this section, the Commissioner may impose a civil penalty against the health plan of no more than \$500.00 per day for each day a claim remains unpaid, with a maximum penalty for each claim of \$5, 000.00 assessed from the day after the date payment or reimbursement was due. Each claim for payment or reimbursement for which payment or reimbursement or notice is not provided... shall constitute a separate violation. " 18 VSA § 9418.*

Wyoming law states: *"In any actions or proceedings commenced against any insurance company... if it is determined that the company refuses to pay the full amount of a loss covered by the policy and that the refusal is unreasonable or without causes, any court in which judgment is rendered for a claimant may also award a reasonable sum as an attorney's fee and interest at ten percent per year. " Wyo. Stat. § 26-15-124.*

D. Incomplete and Contested Claims

1. General

Payers often contest claims on the grounds that they are not "clean claims," that a patient is not a covered beneficiary, that services provided were not medically necessary or covered by the contract, or the manner in which the services were accessed or provided was faulty or not consistent with the contract. This should be addressed by requiring that carriers act promptly and appropriately in such instances and also by focusing on ways to improve physicians' ability to file complete claims in accordance with carriers' requirements.

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2. Notification

a. Notice of all defects

Carriers should notify providers in a timely manner if they are contesting a claim or if they believe a claim to be incomplete. This notification should specify all problems with the claim, and grant the insured the opportunity to provide any additional information. Carriers should not be allowed to notify a provider about one defect, receive the necessary information, and later notify the provider of another defect detectable at the time of the original notification. This is important because according to statutory provisions in most states, the time period for paying claims begins to run at the time the claim is deemed "clean."

b. Time allowed for notification

Most laws include some requirement that notification of any defects in the claim must occur within a specified number of days. Georgia requires that insurers notify a subscriber within 15 days of a denial or defect and request any additional needed information; Nevada's law allows 20 days for notification of defects. For example, Colorado, New York and Virginia require such notification within 30 days of the receipt of the claim. Hawaii requires notification of defects within 15 calendar days for written claims and 7 calendar days for electronic claims.

c. Uniform format for denials

One idea promoted in New Jersey is that notices of denied or defective claims shall be made on a specific form with a uniform format.

d. Examples of legislative language

New York's law requires that if a plan is contesting a claim, it must *"notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim: (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable: or (2) to request all additional information needed to determine liability to pay the claim or make the health care payment. "*

Texas law states: *Not later than the 45th days after the date that the health maintenance organization receives a clean claim ... the health maintenance organization shall: (1) pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization; (2) pay the portion of the claim that is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or (3) notify the physician or provider in writing why the claim will not be paid "* Tx. Stat. Ann. Art. 20A.18B

3. Partial Payment Due

Carriers should be required to pay any portion of the claim that is complete and uncontested. This discourages carriers from finding fault with a small portion of a large claim in an effort to delay payment.

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a. Example of legislative language

"In a case where the obligation of an insurer or an organization... to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation.. for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days... [of the basis for the delay on the remaining portion of the claim and request "all additional information needed to determine liability to pay the claim or make the health care payment. " J Laws of New York, Chapter. 637, §3224-A.(B)

4. Definitions of "Clean Claims" and "Contested Claims"

It is wise to include a statutory statement outlining when carriers can rightfully delay or deny payment, either because a provider fails to submit a clean claim or because the carrier is contesting the claim. Obviously, this requires a definition of those key terms, examples of which follow:

"Clean claim " means "a claim due a provider that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim[. J" Assurance of Discontinuance, New York State Attorney General in the Matter of Oxford Health Plans, Inc.

"Clean claim " means "a properly completed billing instrument, paper or electronic, that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation... (c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.... " 2000 Kentucky SB 279.

Definition of "contest " means "the circumstance in which the health plan was not provided with: (a) Sufficient information needed to determine payer liability; or (B) Reasonable access to information needed to determine the liability or basis for payment of the claim §9418 (3). 18 VSA § 99418.

"(A) 'Clean claim ' means a claim received by a health insurance entity for adjudication, and which requires not further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health insurer. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this act (B) A clean claim does not include a duplicate claim. A duplicate claim means an original claim and its duplicate when the duplicate is filed within 30 days of the original claim. (C) A clean claim does not include any claim submitted more than 90 days after the date of service. (C) The definition of clean claim includes resubmitted paper claims with previously identified deficiencies corrected " Tenn. Code Ann. § 56-7-105.

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"Clean claim " is defined as a claim (1) that has no material defect or impropriety (including any lack of any reasonably required substantiation or documentation) which substantially prevents timely payment from being made on the claim, or (2) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with the law. " Virginia Code Ann. § 38.2-3407.15.

5. Uniform Claims Forms

Part of the problem of carriers denying claims as "unclean" stems from the fact that in all but a few states, carriers are allowed to use their own specific claims forms. This means that a physician's practice must keep track of each payer's specific forms, which can differ a great deal in terms of both content and format. This makes the likelihood of submitting claims that do not comply with the particular requirements of each plan much greater. For two decades, Oregon has required a uniform claim form with the Oregon Insurance Department publishes (the form tracks the HCFA 1500 form). According to Oregon Medical Association staff, this has virtually eliminated "clean claims" problems.

Enacted in 1999, Louisiana's law calls for the Department of Insurance to establish a clean claim form for use in the state. Several other states, including Colorado, Kentucky, New Jersey, New Mexico and New York also require the creation and use of uniform claims forms.

E. Anti-Retaliation Language

To counter the common fear among physicians that if they take formal action against delinquent health carriers, the carriers will retaliate by dropping them from their networks, it is critical to include language that such retaliation shall not occur. State law should include a requirement that upon termination from a health carrier network, such carrier shall provide written reasons as to the termination. Many states have enacted this type of requirement as a component of general patient protection legislation. Any new legislation to ensure timely payment should include a provision that references the relevant state law and states that it applies to situations where physicians contest late payment by health carriers.

E. Additional Requirements

1. Status of Claims

Some states require carriers to establish some method whereby providers and patients can access information as to the status of a claim. In New Jersey, payers are required to provide covered persons and eligible health care providers with a toll-free telephone number for making inquiries regarding paid claims or pending claims. Kentucky requires that, by January 1, 2001, insurers have in place a mechanism to inform providers of claims status. This may be done either electronically, or by noting the status on the remittance.

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II. ENFORCEMENT AND OVERSIGHT

III. A. Regulatory Agency

Legislation addressing the problem of late payment should include an explicit assignment of responsibility for enforcement to a state agency. In most states, this agency would be the Department of Insurance, although in some states, the Department of Health would likely be involved in investigating complaints, particularly against HMOs. The appropriate agency should be required to designate a specific unit and process for handling complaints regarding late payment. In addition to a primary enforcement agency, the legislation should stipulate that the state agency shall inform the state Attorney General of repeat offenders and/or particularly egregious payment practices by insurers. The law shall require the Attorney General to take action against such offenders.

B. Independent / External Review Board

An option to designating a state agency is to develop external review boards to handle complaints relating to payment.

C. Trigger for Enforcement

The legislation should specify that the oversight agency shall investigate all complaints made relating to late payment, whether by a provider or a consumer. The agency shall not require that the complainant establish a "pattern and practice" or similar showing of repeated or gross misconduct by a payer before it will investigate a complaint.

D. Mandatory Arbitration

Typically required by contract, there is increasing interest in legislating mandatory arbitration of disputes relating to payment of claims.

For example, Vermont legislation would allow that for arbitration at the option of either the provider or the carrier. Vermont HR672 (1998).

E. "Hot-line" Complaints: The New York Approach

The New York Department of Insurance created a toll-free hotline phone number for physicians and other providers to call when they have unpaid claims in violation of New York law (45 days after the clean claim is submitted). Also, an amendment to New York's prompt payment statute grants the Superintendent of Insurance the authority to impose a \$500 per day fine in addition to interest penalties. This hotline makes it easier for providers to register complaints, and requires that the DOI set up a specific unit with dedicated staff for this purpose.

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F. Data Collection and Audits

In an effort to effectively track carriers' payment practices, it is recommended that state laws include periodic reporting requirements for insurance entities. Several states' prompt payment laws currently place this type of reporting requirement on carriers. The New Jersey law requires payers to maintain a detailed record of claims data and report such data to the insurance commissioner on at least a quarterly basis. In Kentucky, insurers must submit data on the number of claims paid within and after the proper timeframe, and indicate the number of days before each claim was finally adjudicated. Late payment timeframes must be broken down and reported in the following categories: 31-60 days; 61-90 days; and 91 days or more.

One way to combat particularly egregious payment practices is to impose a requirement of independent audits to determine how quickly carriers are paying claims. Such audits should be conducted on at least an annual basis for all carriers. Where there are numerous complaints against a particular carrier, state regulators should order more frequent and intensive audits. Audits should be paid for at the carriers' expense. New Jersey payers are audited annually (at the payer's expense) based on data collected by payers. The findings are then submitted to the insurance commissioner, governor and legislature.

IV. RELATED ISSUE: TIMELY PAYMENT OF CAPITATION PAYMENTS

V. A. General

Payment delays from managed care organizations that capitate providers often take a different form than in the fee for service market. In some cases, managed care organizations have delayed capitation payments to a provider for several months after the physician becomes legally responsible for a beneficiary's medical care. A typical example would be when a patient chooses (or is assigned) a primary care physician that contracts with his or her MCO. The patient does not see

the physician for several months for treatment, and the MCO doesn't pay the first capitation installment until the beneficiary actually receives medical care. In some cases, the MCO doesn't notify the physician that he or she is responsible for that beneficiaries' care. Another example would be where a MCO does not require a beneficiary to choose a primary care provider upon enrollment. Rather, the MCO allows the beneficiary to wait until he or she needs treatment of some kind to choose a primary care provider. The MCO has collect premiums from that beneficiary for the interim months, but has failed to pass a capitated amount on to one of its contracting physicians. Each scenario undermines a physician's ability to finance the beneficiary's health care costs from capitated payments.

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B. Model Legislation

AMA model legislation addresses this issue. This legislation requires that: (a) Upon selection or assignment of a managed care enrollee to a primary care physician, the managed care organization shall provide the primary care physician with written notice of the assignment or selection; (b) No later than the 60th day following the date an enrollee has selected or has been assigned a primary care physician, a MCO shall begin payment of capitated amounts to the enrollee's primary care physician calculated from the time of enrollment. If selection or assignment does not occur at the time of enrolment, capitation which would otherwise have been paid to a selected primary care physician had selection been made shall be reserved as a capitation payable until such time as an enrollee makes a selection; and (c) If an enrollee does not select a primary care physician at the time of application or enrollment, a MCO shall assign an enrollee to a primary care physician located within the zip code nearest the enrollee's residence or place of employment; (d) A MCO shall inform an enrollee of the name, address, and telephone number assignment of an enrollee to that physician by the MCO of the primary care physician to whom the enrollee has been assigned and of the enrollee's right to select a different primary care physician. An enrollee shall have the right at any time to reject the physician or provider assigned and to select another physician from the list of primary care physicians for the MCO; (e) A MCO shall notify a physician of the selection of the physician as a primary care physician by an enrollee within 30 working days of the selection or assignment; and (f) Any MCO that violates provisions of this Act shall be subject to penalties imposed by the [state oversight authority] in accordance with state law.

C. Texas Law

Texas' legislature enacted a law that requires HMOs to begin payment of capitated amounts to enrollee's primary care physician / provider, calculated from the date of enrollment, no later than the 60th day following the date an enrollee selected or was assigned to the PCP. If selection doesn't occur at enrollment, the capitated funds for that enrollee must be reserved for payment to a PCP upon selection. HMOs are also required to notify PCPs of an enrollee's selection or assignment within 30 working days of such selection or assignment. 1997 Tex. Gen. Laws 1026.