THE SENATE
TWENTY-EIGHTH LEGISLATURE, 2015
STATE OF HAWAII

S.B. NO. 736 S.D. 1 H.D. 2

A BILL FOR AN ACT

RELATING TO INSURANCE.

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

1 SECTION 1. The legislature finds that insurance recoupment
2 occurs when a health insurance plan pays benefits to providers
3 and later seeks reimbursement for the benefits, after the health
4 insurance plan determines that the benefits were paid out in
5 error. Although health care providers in Hawaii have a time
6 limit in which to submit claims to health insurance plans, there
7 is no similar time limit that prevents health insurance plans
8 from attempting to recoup funds previously paid to health care
9 providers. There is also no time limitation for health care
10 providers to return previously paid funds that the providers
11 identified as erroneously paid.

12 The legislature further finds that pursuant to Senate
13 Concurrent Resolution No. 129, S.D. 1, Regular Session of 2013,
14 a working group was convened to study insurance recoupment,
15 although the working group was not able to recommend proposed
16 legislation based on insurance recoupment at that time.
17 However, the legislature finds that there have been recent

reports of new physician contracts being issued that provide for no time limits in recoupment efforts in cases of suspected or unintentional fraud, in spite of a six-year state statute of limitations on fraud. Accordingly, these events lead the legislature to conclude that additional legislative scrutiny of insurance recoupment is needed.

The purpose of this Act is to:

(1) Require an entity to send written notice to a health care provider at least thirty calendar days prior to initiating any recoupment or offset demand efforts; and

(2) Prohibit an entity from initiating any recoupment or offset efforts more than eighteen months after an initial claim payment was received by a health care provider, with specific exceptions.

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

"**§431:13-108 Reimbursement for accident and health or sickness insurance benefits.** (a) This section applies to accident and health or sickness [~~insurance providers~~] insurers issuing comprehensive medical plans under part I of article 10A

1 of chapter 431, mutual benefit societies under article 1 of
2 chapter 432, dental service corporations under chapter 423, and
3 health maintenance organizations under chapter 432D.
4 (b) Unless shorter payment timeframes are otherwise
5 specified in a contract, an entity shall reimburse a claim that
6 is not contested or denied not more than thirty calendar days
7 after receiving the claim filed in writing, or fifteen calendar
8 days after receiving the claim filed electronically, as
9 appropriate.
10 (c) If a claim is contested or denied or requires more
11 time for review by an entity, the entity shall notify the health
12 care provider in writing or electronically not more than fifteen
13 calendar days after receiving a claim filed in writing, or not
14 more than seven calendar days after receiving a claim filed
15 electronically, as appropriate. The notice shall identify the
16 contested portion of the claim and the specific reason for
17 contesting or denying the claim, and may request additional
18 information; provided that a notice shall not be required if the
19 entity provides a reimbursement report containing the
20 information, at least monthly, to the provider.

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

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

1 The commissioner may suspend the accrual of interest if the
2 commissioner determines that the entity's failure to pay a claim
3 within the applicable time limitations was the result of a major
4 disaster or of an unanticipated major computer system failure.
5 (h) Any interest that accrues in a sum of at least $2 on a
6 delayed clean claim in this section shall be automatically added
7 by the entity to the amount of the unpaid claim due the
8 provider.
9 (i) Prior to initiating any recoupment or offset demand
10 efforts, an entity shall send a written notice to a health care
11 provider at least thirty calendar days prior to engaging in the
12 recoupment or offset efforts. The following information shall
13 be prominently displayed on the written notice:
14 (1) The patient's name;
15 (2) The date health care services were provided;
16 (3) The payment amount received by the health care
17 provider;
18 (4) The reason for the recoupment or offset; and
19 (5) The telephone number or mailing address through which
20 a health care provider may initiate an appeal along
21 with the deadline for initiating an appeal. Any

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

1 [~~(i)~~] (k) In determining the penalties under section 431:13-
2 201 for a violation of this section, the commissioner shall
3 consider:
4 (1) The appropriateness of the penalty in relation to the
5 financial resources and good faith of the entity;
6 (2) The gravity of the violation;
7 (3) The history of the entity for previous similar
8 violations;
9 (4) The economic benefit to be derived by the entity and
10 the economic impact upon the health care facility or
11 health care provider resulting from the violation; and
12 (5) Any other relevant factors bearing upon the violation.
13 [~~(j)~~] (l) As used in this section:
14 "Acute care hospital" means a hospital that provides
15 inpatient medical care and other related services for surgery or
16 acute medical conditions or injuries (usually for a short term
17 illness or condition).
18 "Claim" means any claim, bill, or request for payment for
19 all or any portion of health care services provided by a health
20 care provider of services submitted by an individual or pursuant
21 to a contract or agreement with an entity, using the entity's

1 standard claim form with all required fields completed with
2 correct and complete information.
3 "Clean claim" means a claim in which the information in the
4 possession of an entity adequately indicates that:
5 (1) The claim is for a covered health care service
6 provided by an eligible health care provider to a
7 covered person under the contract;
8 (2) The claim has no material defect or impropriety;
9 (3) There is no dispute regarding the amount claimed; and
10 (4) The payer has no reason to believe that the claim was
11 submitted fraudulently.
12 The term does not include:
13 (1) Claims for payment of expenses incurred during a
14 period of time when premiums were delinquent;
15 (2) Claims that are submitted fraudulently or that are
16 based upon material misrepresentations;
17 (3) [~~Medicaid or Medigap claims; and~~] Claims for self-
18 insured employer groups; claims for services rendered
19 to individuals associated with a health care entity
20 through a national participating provider network; or

1 claims for medicaid, medicare, medigap, or other
2 federally financed plan; and
3 (4) Claims that require a coordination of benefits,
4 subrogation, or preexisting condition investigations,
5 or that involve third-party liability.
6 "Contest", "contesting", or "contested" means the
7 circumstances under which an entity was not provided with, or
8 did not have reasonable access to, sufficient information needed
9 to determine payment liability or basis for payment of the
10 claim.
11 "Deny", "denying", or "denied" means the assertion by an
12 entity that it has no liability to pay a claim based upon
13 eligibility of the patient, coverage of a service, medical
14 necessity of a service, liability of another payer, or other
15 grounds.
16 "Entity" means accident and health or sickness insurance
17 providers under part I of article 10A of chapter 431, mutual
18 benefit societies under article 1 of chapter 432, dental service
19 corporations under chapter 423, and health maintenance
20 organizations under chapter 432D.

1 "Fraud" shall have the same meaning as in section
2 431:2-403.
3 "Health care facility" shall have the same meaning as in
4 section [~~327D-2.~~] 323D-2; provided that health care facility
5 shall not include an acute care hospital.
6 "Health care provider" means a Hawaii health care facility,
7 physician, nurse, or any other provider of health care services
8 covered by an entity."
9 SECTION 3. Statutory material to be repealed is bracketed
10 and stricken. New statutory material is underscored.
11 SECTION 4. This Act shall take effect upon its approval.

S.B. NO. 736 S.D. 1 H.D. 2

Report Title:
Insurance; Reimbursement for Benefits; Recoupment

Description:
Requires at least 30 days written notice prior to recoupment or offset demand efforts for health insurance payments to health care providers. Prohibits recoupment or offset efforts more than 18 months after an initial claim payment was received, with specific exceptions. (SB736 HD2)

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