



**GOV. MSG. NO. 1133**

EXECUTIVE CHAMBERS  
HONOLULU

DAVID Y. IGE  
GOVERNOR

May 5, 2015

The Honorable Ronald D. Kouchi,  
President  
and Members of the Senate  
Twenty-Eighth State Legislature  
State Capitol, Room 409  
Honolulu, Hawai'i 96813

The Honorable Joseph M. Souki,  
Speaker and Members of the  
House of Representatives  
Twenty-Eighth State Legislature  
State Capitol, Room 431  
Honolulu, Hawai'i 96813

Dear President Kouchi, Speaker Souki, and Members of the Legislature:

This is to inform you that on May 5, 2015, the following bill was signed into law:

SB736 SD1 HD2

RELATING TO INSURANCE  
**ACT 033 (15)**

Sincerely,

A handwritten signature in black ink that reads "David Y. Ige".

DAVID Y. IGE  
Governor, State of Hawai'i

*[Handwritten signature]*

15 MAY -5 P5:33

SENATOR RONALD D. KOUCHI  
RECEIVED MAY 05 2015  
@3:51PM

RECEIVED  
THE SENATE  
CLERK'S OFFICE  
STATE OF HAWAII

Approved by the Governor

on     MAY    5    2015      
THE SENATE  
TWENTY-EIGHTH LEGISLATURE, 2015  
STATE OF HAWAII

ACT 033  
S.B. NO. 736  
S.D. 1  
H.D. 2

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# 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



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

7 The purpose of this Act is to:

- 8 (1) Require an entity to send written notice to a health  
9 care provider at least thirty calendar days prior to  
10 initiating any recoupment or offset demand efforts;  
11 and
- 12 (2) Prohibit an entity from initiating any recoupment or  
13 offset efforts more than eighteen months after an  
14 initial claim payment was received by a health care  
15 provider, with specific exceptions.

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

18 **"§431:13-108 Reimbursement for accident and health or**  
19 **sickness insurance benefits.** (a) This section applies to  
20 accident and health or sickness [~~insurance providers~~] insurers  
21 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 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.

APPROVED this       5       day of       MAY       , 2015



GOVERNOR OF THE STATE OF HAWAII