A BILL FOR AN ACT

RELATING TO INSURANCE:

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

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

The legislature further finds that pursuant to Senate Concurrent Resolution No. 129, S.D. 1, Regular Session of 2013, a working group was convened to study insurance recoupment, although the working group was not able to recommend proposed legislation based on insurance recoupment at that time. 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 [insurers] insurers issuing comprehensive medical plans under part I of article 10A
of chapter 431, mutual benefit societies under article 1 of
chapter 432, dental service corporations under chapter 423, and
health maintenance organizations under chapter 432D.

(b) Unless shorter payment timeframes are otherwise
specified in a contract, an entity shall reimburse a claim that
is not contested or denied not more than thirty calendar days
after receiving the claim filed in writing, or fifteen calendar
days after receiving the claim filed electronically, as
appropriate.

(c) If a claim is contested or denied or requires more
time for review by an entity, the entity shall notify the health
care provider in writing or electronically not more than fifteen
calendar days after receiving a claim filed in writing, or not
more than seven calendar days after receiving a claim filed
electronically, as appropriate. The notice shall identify the
contested portion of the claim and the specific reason for
contesting or denying the claim, and may request additional
information; provided that a notice shall not be required if the
entity provides a reimbursement report containing the
information, at least monthly, to the provider.
(d) Every entity shall implement and make accessible to providers a system that provides verification of enrollee eligibility under plans offered by the entity.

(e) If information received pursuant to a request for additional information is satisfactory to warrant paying the claim, the claim shall be paid not more than thirty calendar days after receiving the additional information in writing, or not more than fifteen calendar days after receiving the additional information filed electronically, as appropriate.

(f) Payment of a claim under this section shall be effective upon the date of the postmark of the mailing of the payment, or the date of the electronic transfer of the payment, as applicable.

(g) Notwithstanding section 478-2 to the contrary, interest shall be allowed at a rate of fifteen per cent a year for money owed by an entity on payment of a claim exceeding the applicable time limitations under this section, as follows:

(1) For an uncontested claim:

(A) Filed in writing, interest from the first calendar day after the thirty-day period in subsection (b); or
(B) Filed electronically, interest from the first
  calendar day after the fifteen-day period in
  subsection (b);

(2) For a contested claim filed in writing:
  (A) For which notice was provided under subsection
       (c), interest from the first calendar day thirty
days after the date the additional information is
  received; or

  (B) For which notice was not provided within the time
specified under subsection (c), interest from the
  first calendar day after the claim is received;
or

(3) For a contested claim filed electronically:
  (A) For which notice was provided under subsection
       (c), interest from the first calendar day fifteen
days after the additional information is
  received; or

  (B) For which notice was not provided within the time
specified under subsection (c), interest from the
  first calendar day after the claim is received.
The commissioner may suspend the accrual of interest if the commissioner determines that the entity's failure to pay a claim within the applicable time limitations was the result of a major disaster or of an unanticipated major computer system failure.

(h) Any interest that accrues in a sum of at least $2 on a delayed clean claim in this section shall be automatically added by the entity to the amount of the unpaid claim due the provider.

(i) Prior to initiating any recoupment or offset demand efforts, an entity shall send a written notice to a health care provider at least thirty calendar days prior to engaging in the recoupment or offset efforts. The following information shall be prominently displayed on the written notice:

1. The patient's name;
2. The date health care services were provided;
3. The payment amount received by the health care provider;
4. The reason for the recoupment or offset; and
5. The telephone number or mailing address through which a health care provider may initiate an appeal along with the deadline for initiating an appeal. Any
appeal of a recoupment or offset shall be made by a 
health care provider within sixty days after the 
receipt of the written notice.

(j) An entity shall not initiate recoupment or offset 
efforts more than eighteen months after the initial claim 
payment was received by the health care provider or health care 
entity; provided that this time limit shall not apply to the 
initiation of recoupment or offset efforts: to claims for self- 
insured employer groups; for services rendered to individuals 
associated with a health care entity through a national 
participating provider network; or for claims for medicaid, 
medicare, medigap, or other federally financed plan; provided 
that this section shall not be construed to prevent entities 
from resolving claims that involve coordination of benefits, 
subrogation, or preexisting condition investigations, or that 
involves third-party liability beyond the eighteen month time 
limit; provided further that in cases of fraud or material 
misrepresentation, an entity shall not initiate recoupment or 
offset efforts more than seventy-two months after the initial 
claim payment was received by the health care provider or health 
care entity.
In determining the penalties under section 431:13-201 for a violation of this section, the commissioner shall consider:

(1) The appropriateness of the penalty in relation to the financial resources and good faith of the entity;

(2) The gravity of the violation;

(3) The history of the entity for previous similar violations;

(4) The economic benefit to be derived by the entity and the economic impact upon the health care facility or health care provider resulting from the violation; and

(5) Any other relevant factors bearing upon the violation.

(1) As used in this section:

"Acute care hospital" means a hospital that provides inpatient medical care and other related services for surgery or acute medical conditions or injuries (usually for a short term illness or condition).

"Claim" means any claim, bill, or request for payment for all or any portion of health care services provided by a health care provider of services submitted by an individual or pursuant to a contract or agreement with an entity, using the entity's
standard claim form with all required fields completed with correct and complete information.

"Clean claim" means a claim in which the information in the possession of an entity adequately indicates that:

1. The claim is for a covered health care service provided by an eligible health care provider to a covered person under the contract;
2. The claim has no material defect or impropriety;
3. There is no dispute regarding the amount claimed; and
4. The payer has no reason to believe that the claim was submitted fraudulently.

The term does not include:

1. Claims for payment of expenses incurred during a period of time when premiums were delinquent;
2. Claims that are submitted fraudulently or that are based upon material misrepresentations;
3. [Medicaid or Medigap claims; and] Claims for self-insured employer groups; claims for services rendered to individuals associated with a health care entity through a national participating provider network; or
claims for medicaid, medicare, medigap, or other federally financed plan; and

(4) Claims that require a coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability.

"Contest", "contesting", or "contested" means the circumstances under which an entity was not provided with, or did not have reasonable access to, sufficient information needed to determine payment liability or basis for payment of the claim.

"Deny", "denying", or "denied" means the assertion by an entity that it has no liability to pay a claim based upon eligibility of the patient, coverage of a service, medical necessity of a service, liability of another payer, or other grounds.

"Entity" means accident and health or sickness insurance providers under part I of article 10A of chapter 431, mutual benefit societies under article 1 of chapter 432, dental service corporations under chapter 423, and health maintenance organizations under chapter 432D.
"Fraud" shall have the same meaning as in section 431:2-403.

"Health care facility" shall have the same meaning as in section [327D-2] 323D-2; provided that health care facility shall not include an acute care hospital.

"Health care provider" means a Hawaii health care facility, physician, nurse, or any other provider of health care services covered by an entity."

SECTION 3. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 4. This Act shall take effect upon its approval.
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)

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