SECOND REGULAR SESSION

HOUSE BILL NO. 1498

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES JONES (89) (Sponsor), SCHAAF, CARTER, FUNDERBURK, LAMPE, ROORDA, COX, COLONA, RUESTMAN AND GRISAMORE (Co-sponsors).

3347L.02I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 376.383, RSMo, and to enact in lieu thereof one new section relating to the payment of health insurance claims.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Section 376.383, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 376.383, to read as follows:

376.383. 1. For purposes of this section and section 376.384, the following terms shall mean:

(1) "Claimant", any individual, corporation, association, partnership or other legal entity asserting a right to payment arising out of a contract or a contingency or loss covered under a health benefit plan as defined in section 376.1350;

(2) **"Clean claim", a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment;**

(3) "Deny" or "denial", when the health carrier refuses to reimburse all or part of the claim;

[(3)**] (4)** "Health carrier", health carrier as defined in section 376.1350**[**,**] and any self-insured health plan to the extent allowed by federal law;** except that health carrier shall not include a workers' compensation carrier providing benefits to an employee pursuant to chapter 287**[**, RSMo**] . For purposes of this section and section 376.384, third-party contractors are health carriers**;

[(4)**] (5)** "Health care provider", health care provider as defined in section 376.1350;

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

[(5)**] (6)** "Health care services", health care services as defined in section 376.1350;

[(6)**] (7)** "Processing days", number of days the health carrier **or any of its agents, subsidiaries, contractors, subcontractors, or third-party contractors** has the claim in its possession. Processing days shall not include days in which the health carrier is waiting for a response to a request for additional information **directly from the claimant**;

[(7)**] (8)** "Request for additional information", **[**when the health carrier requests information from the claimant to determine if all or part of the claim will be reimbursed**] a health carrier's electronic request for additional information from the claimant specifying all of the documentation or information necessary to process all of the claim, or all of the claims on a multi-claim form, as clean claim for payment**;

[(8) "Suspends the claim", giving notice to the claimant specifying the reason the claim is not yet paid, including but not limited to grounds as listed in the contract between the claimant and the health carrier; and**]**

(9) "Third-party contractor", a third party contracted with the health carrier to receive or process claims for reimbursement of health care services.

2. **Within two working days after receipt of an electronically filed claim by a health carrier or a third-party contractor, a health carrier shall send an electronic acknowledgment of the date of receipt.**

3. Within **[**ten working**] fifteen** days after receipt of a claim **filed** by a health carrier or a third-party contractor, a health carrier shall**[**:

(1) Send an acknowledgment of the date of receipt; or

(2)**]** send **an electronic** notice of the status of the claim that **[**includes**] notifies the claimant:**

(1) Whether the claim is a clean claim as defined in this section; or

(2) The claim requires additional information from the claimant.

If the claim is a clean claim, the health carrier shall pay or deny the claim. If the claim requires additional information, the health carrier shall include in the notice a request for additional information. If a health carrier pays the claim, **[**subdivisions (1) and (2)**] this subsection** shall not apply.

[3.**] 4.** Within fifteen days after receipt of additional information by a health carrier or a third-party contractor, a health carrier shall pay the claim or any undisputed part of the claim in accordance with this section or send **[**a**] an electronic** notice of receipt and status of the claim:

(1) That denies all or part of the claim and specifies each reason for denial; or

(2) That makes a final request for additional information.

[4.**] 5.** Within fifteen days after the day on which the health carrier or a third-party contractor receives the additional requested information in response to a final request for information, it shall pay the claim or any undisputed part of the claim or deny **[**or suspend**]** the claim.

[5.**] 6.** If the health carrier has not paid the claimant on or before the forty-fifth **processing** day from the date of receipt of the claim, the health carrier shall pay the claimant one percent interest per month **and a penalty in an amount equal to one-tenth of the claim per day**. The interest **and penalty** shall be calculated based upon the unpaid balance of the claim **as of the forty-fifth processing day**. The interest **and penalty** paid pursuant to this subsection shall be included in any late reimbursement without the necessity for the person that filed the original claim to make an additional claim for that interest **and penalty**. A health carrier may combine interest payments and make payment once the aggregate amount reaches **[**five**] one hundred** dollars. **Any claim which has been properly denied before the forty-fifth processing day under this section and section 376.384 shall not be subject to interest or penalties. Such interest and penalties shall cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of such claim. Upon a finding by a court of competent jurisdiction that the health carrier failed to pay a claim, interest, or penalty without good cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a health care provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense.**

[6. If a health carrier fails to pay, deny or suspend the claim within forty processing days, and has received, on or after the fortieth day, notice from the health care provider that such claim has not been paid, denied or suspended, the health carrier shall, in addition to monthly interest due, pay to the claimant per day an amount of fifty percent of the claim but not to exceed twenty dollars for failure to pay all or part of a claim or interest due thereon or deny or suspend as required by this section. Such penalty shall not accrue for more than thirty days unless the claimant provides a second written or electronic notice on or after the thirty days to the health carrier that the claim remains unpaid and that penalties are claimed to be due pursuant to this section. Penalties shall cease if the health carrier pays, denies or suspends the claim. Said penalty shall also cease to accrue on the day after a petition is filed in a court of competent jurisdiction to recover payment of said claim. Upon a finding by a court of competent jurisdiction that the health carrier failed to pay a claim, interest or penalty without reasonable cause, the court shall enter judgment for reasonable attorney fees for services necessary for recovery. Upon a finding that a provider filed suit without reasonable grounds to recover a claim, the court shall award the health carrier reasonable attorney fees necessary to the defense.**]**

7. The department of insurance, financial institutions and professional registration shall monitor **[**suspensions**] denials** and determine whether the health carrier acted reasonably.

8. If a health carrier or third-party contractor has reasonable grounds to believe that a fraudulent claim is being made, the health carrier or third-party contractor shall notify the department of insurance, financial institutions and professional registration of the fraudulent claim pursuant to sections 375.991 to 375.994, RSMo.

9. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied. **Any claim for which the health carrier has not communicated a specific reason for the denial shall not be considered denied under this section or section 376.384.**

10. Requests for additional information shall specify **[**what**] all of the documentation and** additional information **that** is necessary to process **all of** the claim**, or all of the claims on a multi-claim form, as a clean claim** for payment. Information requested shall be reasonable and pertain **solely** to the health carrier's determination of liability. The health carrier shall acknowledge receipt of the requested additional information to the claimant within five working days or pay the claim.

11. No health carrier or any of its agents, subsidiaries, contractors, repricers, or subcontractors shall request a refund or offset against a claim more than twelve months after a health carrier has paid a claim, except in cases of fraud or misrepresentation by the health care provider.

12. All health carriers' agents, subsidiaries, contractors, repricers, and subcontractors shall abide by the terms of the contract between the health carrier and the health care provider as those terms relate to the payment of claims and requesting any refund or offset against a claim that has been paid.

13. Beginning January 1, 2011, a health carrier responding to a patient financial responsibility inquiry utilizing the HIPAA 270/271 electronic eligibility response transaction code sets shall include all six eligibility or benefit information codes: co-payment, coinsurance, deductible, out-of-pocket maximum, remaining deductible amount, and other cost containment elements. The department of insurance, financial institutions and professional registration shall develop a set of best practices to be used by health carriers and health care providers to standardize electronic data exchange of HIPAA 270/271 health care eligibility benefit inquiry/response transaction code sets. The best practices shall be consistent with but no more stringent that the federal administrative simplification standards adopted under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

. . . . . ✓