GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H **1**

HOUSE BILL 1537*

Short Title: Prompt Pay. (Public)

Sponsors: Representatives Nye, Insko, Nesbitt, Cunningham, Justus; Buchanan, Cansler, Gardner, Hackney, Luebke, Russell, Wainwright, Warner, West, and C. Wilson.

Referred to: Rules, Calendar and Operations of the House.

May 16, 2000

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FOR THE PROMPT PAYMENT OF CLAIMS UNDER HEALTH BENEFIT PLANS AND TO MAKE CONFORMING AMENDMENTS TO RELATED CLAIM PAYMENT LAWS.

The General Assembly of North Carolina enacts:

Section. 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its

representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Credit.
b. Disability income.
c. Coverage issued as a supplement to liability insurance.
d. Hospital income or indemnity.
e. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.
f. Medical payments under motor vehicle or homeowners' insurance policies.
g. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
h. Workers' compensation.

(2) 'Claimant' includes a health care provider or facility that is responsible for directly making the claim with an insurer, an insured, or an insured's legal representative.

(3) 'Health care facility' means a facility that is licensed under Chapter 131E or 122C of the General Statutes in which health care services are provided to patients.

(4) 'Health care provider' means an individual who is licensed, certified, or otherwise authorized under Chapter 90 of the General Statutes to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

(5) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that writes a health benefit plan.

(b) An insurer shall, within 30 days after receipt of a claim, send by electronic or paper mail to the claimant:

(1) Payment of the claim,
(2) Notice of denial of the claim,
(3) Notice that the proof of loss is inadequate or incomplete, or
(4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.

(c) If the claim is denied, the notice shall include the specific reason or reasons for the denial. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, the notice shall contain the specific reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If a claim is denied or contested

in part, the insurer shall pay the undisputed portion of the claim within 30 days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.

(d) If an insurer requests additional information under subsection (c) of this section and the insurer does not receive the additional information within 90 days after the request was made, the insurer shall deny the claim and send the notice of denial to the claimant in accordance with subsection (c) of this section. The insurer shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. The insurer shall inform the claimant in the notice that the claim will be reopened if the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.

(e) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the rate of 18 percent (18%) per year, beginning on the date on which the claim should have been paid. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant. This subsection does not apply to claims for benefits that are not covered by the health benefit plan; nor does this subsection apply to deductibles, co-payments, or other amounts for which the insurer is not liable.

(f) Insurers may require that claims be submitted within 180 days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. Failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the insured or the insured's legal representative to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

(g) If a claim for which the claimant is a health care provider or health care facility has not been paid within 60 days after receipt of the initial claim, the insurer shall send a claim status report to the insured. The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall send a claim status report to the insured every 30 days after the previous report was sent.

(h) Any retroactive reductions of payments or demands for refund of previous overpayments that are because retroactive review-of-coverage decisions or payment levels shall be reconciled for specific claims unless the insurer and health care provider or health care facility agree to other reconciliation methods and terms. Any retroactive demands by health care providers or health care facilities for payment because of

underpayments or nonpayments for covered services shall be reconciled for specific claims unless the insurer and health care provider or health care facility agree to other reconciliation methods and terms. The period for which retroactive adjustments may be made may be specified in the contract between the insurer and health care provider or health care facility.

(i) As used in this subsection, 'copayment or deductible' means the portion of a charge for services covered by a health benefit plan that, under the plan's terms, it is the obligation of the insured to pay. No health care provider or health care facility shall directly or indirectly seek payment or collection of the claim, other than a copayment or deductible, from an insured or an insured's legal representative while the claim is being resolved under this section. No health care provider or health care facility shall report an insured or an insured's legal representative to any credit reporting agency while the claim is being resolved under this section. A violation of this subsection by a health care provider or health care facility is a violation of Article 2 of Chapter 75 of the General Statutes.

(j) Every insurer shall maintain records of its activities under this section, including records of when each claim was paid, denied, or pended, and the insurer's review and handling of each claim under this section, as well as documentation sufficient to demonstrate compliance with this section. The information to be included in these records and the maintenance of these records by the insurer, including electronic reproduction and storage, shall be governed by rules adopted by the Commissioner.

(k) A violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70.

(l) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material party by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages."

Section 2. G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes an insured, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer. This subsection does not apply to insurers subject to G.S. 58-3-225."

Section 3. G.S. 58-51-15(a)(7) reads as rewritten:

"(7) A provision in the substance of the following language:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in the case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss

within ~~90~~ 180 days after the termination of the period for which the insurer is liable and in case of a claim for any other loss within ~~90~~ 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal ~~capacity,~~ capacity of the insured, later than one year from the time proof is otherwise required."

Section 4. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of the act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 5. This act becomes effective July 1, 2001, and applies to claims or services rendered on or after July 1, 2001.