

108TH CONGRESS
2D SESSION

S. 2308

To provide for prompt payment and interest on late payments of health care claims.

IN THE SENATE OF THE UNITED STATES

APRIL 8, 2004

Mr. CORZINE (for himself, Mr. REED, Mr. BINGAMAN, Mr. LAUTENBERG, and Ms. CANTWELL) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To provide for prompt payment and interest on late payments of health care claims.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Prompt Payment of
5 Health Benefits Claims Act of 2004”.

6 **SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT IN-**
7 **COME SECURITY ACT OF 1974.**

8 (a) IN GENERAL.—Subpart B of part 7 of subtitle
9 B of title I of the Employee Retirement Income Security

1 Act of 1974 (29 U.S.C. 1185 et seq.) is amended by add-
2 ing at the end the following:

3 **“SEC. 714. PROMPT PAYMENT OF HEALTH BENEFITS**
4 **CLAIMS.**

5 “(a) TIMEFRAME FOR PAYMENT OF COMPLETE
6 CLAIM.—A group health plan, and a health insurance
7 issuer offering group health insurance coverage in connec-
8 tion with a group health plan, shall pay all complete claims
9 and uncontested claims—

10 “(1) in the case of a claim that is submitted
11 electronically, within 14 days of the date on which
12 the claim is submitted; or

13 “(2) in the case of a claim that is not submitted
14 electronically, within 30 days of the date on which
15 the claim is submitted.

16 “(b) PROCEDURES INVOLVING SUBMITTED
17 CLAIMS.—

18 “(1) IN GENERAL.—Not later than 10 days
19 after the date on which a complete claim is sub-
20 mitted, a group health plan, and a health insurance
21 issuer offering group health insurance coverage in
22 connection with a group health plan, shall provide
23 the claimant with a notice that acknowledges receipt
24 of the claim by the plan or issuer. Such notice shall
25 be considered to have been provided on the date on

1 which the notice is mailed or electronically trans-
2 ferred.

3 “(2) CLAIM DEEMED TO BE COMPLETE.—A
4 claim is deemed to be a complete claim under this
5 section if the group health plan or health insurance
6 issuer involved does not provide notice to the claim-
7 ant of any deficiency in the claim within 10 days of
8 the date on which the claim is submitted.

9 “(3) INCOMPLETE CLAIMS.—

10 “(A) IN GENERAL.—If a group health plan
11 or health insurance issuer determines that a
12 claim for health care expenses is incomplete, the
13 plan or issuer shall, not later than the end of
14 the period described in paragraph (2), notify
15 the claimant of such determination. Such notifi-
16 cation shall specify all deficiencies in the claim
17 and shall list all additional information or docu-
18 ments necessary for the proper processing and
19 payment of the claim.

20 “(B) DETERMINATION AFTER SUBMISSION
21 OF ADDITIONAL INFORMATION.—A claim is
22 deemed to be a complete claim under this para-
23 graph if the group health plan or health insur-
24 ance issuer involved does not provide notice to
25 the claimant of any deficiency in the claim with-

1 in 10 days of the date on which additional in-
2 formation is received pursuant to subparagraph
3 (A).

4 “(C) PAYMENT OF UNCONTESTED POR-
5 TION OF A CLAIM.—A group health plan or
6 health insurance issuer shall pay any
7 uncontested portion of a claim in accordance
8 with subsection (a).

9 “(4) OBLIGATION TO PAY.—A claim for health
10 care expenses that is not paid or contested by a
11 group health plan or health insurance issuer within
12 the timeframes set forth in this subsection shall be
13 deemed to be a complete claim and paid by the plan
14 or issuer in accordance with subsection (a).

15 “(c) DATE OF PAYMENT OF CLAIM.—Payment of a
16 complete claim under this section is considered to have
17 been made on the date on which full payment is received
18 by the health care provider.

19 “(d) INTEREST SCHEDULE.—

20 “(1) IN GENERAL.—With respect to a complete
21 claim, a group health plan or health insurance issuer
22 that fails to comply with subsection (a) shall pay the
23 claimant interest on the amount of such claim, from
24 the date on which such payment was due as provided
25 in this section, at the following rates:

1 “(A) 1½ percent per month from the 1st
2 day of nonpayment after payment is due
3 through the 15th day of such nonpayment.

4 “(B) 2 percent per month from the 16th
5 day of such nonpayment through the 45th day
6 of such nonpayment.

7 “(C) 2½ percent per month after the 46th
8 day of such nonpayment.

9 “(2) CONTESTED CLAIMS.—With respect to
10 claims for health care expenses that are contested by
11 the plan or issuer, once such claim is deemed com-
12 plete under subsection (b), the interest rate applica-
13 ble for noncompliance under this subsection shall
14 apply consistent with paragraphs (1) and (2).

15 “(e) PRIVATE RIGHT OF ACTION.—Nothing in this
16 section shall be construed to prohibit or limit a claim or
17 action not covered by the subject matter of this section
18 that any claimant has against a group health plan, or a
19 health insurance issuer.

20 “(f) ANTI-RETALIATION.—Consistent with applicable
21 Federal or State law, a group health plan or health insur-
22 ance issuer shall not retaliate against a claimant for exer-
23 cising a right of action under this section.

24 “(g) FINES AND PENALTIES.—

25 “(1) FINES.—

1 “(A) IN GENERAL.—If a group health plan
2 or health insurance issuer offering group health
3 insurance coverage, willfully and knowingly vio-
4 lates this section or has a pattern of repeated
5 violations of this section, the Secretary shall im-
6 pose a fine not to exceed \$1,000 per claim for
7 each day a response is delinquent beyond the
8 date on which such response is required under
9 this section.

10 “(B) REPEATED VIOLATIONS.—If 3 sepa-
11 rate fines under subparagraph (A) are levied
12 within a 5-year period, the Secretary is author-
13 ized to impose a penalty in an amount not to
14 exceed \$10,000 per claim.

15 “(2) REMEDIAL ACTION PLAN.—Where it is es-
16 tablished that the group health plan or health insur-
17 ance issuer willfully and knowingly violated this sec-
18 tion or has a pattern of repeated violations, the Sec-
19 retary shall require the group health plan or health
20 insurance issuer to—

21 “(A) submit a remedial action plan to the
22 Secretary; and

23 “(B) contact claimants regarding the
24 delays in the processing of claims and inform

1 claimants of steps being taken to improve such
2 delays.

3 “(h) DEFINITIONS.—In this section:

4 “(1) CLAIMANT.—The term ‘claimant’ means a
5 participant, beneficiary or health care provider sub-
6 mitting a claim for payment of health care expenses.

7 “(2) COMPLETE CLAIM.—The term ‘complete
8 claim’ is a claim for payment of covered health care
9 expenses that—

10 “(A) in the case of a claim involving a
11 health care provider that is an institution or
12 other facility or agency that provides health
13 care services, is a properly completed billing in-
14 strument that consists of—

15 “(i) the Health Care Financing Ad-
16 ministration 1450 (UB-92) paper form, or
17 its successor, as adopted by the NUBC,
18 with data element usage consistent with
19 the usage prescribed in the UB-92 Na-
20 tional Uniform Billing Data Elements
21 Specification Manual, and, for claims sub-
22 mitted before October 1, 2002, any State-
23 designated data requirements that are de-
24 termined and approved by the State uni-
25 form billing committee of the State in

1 which the health care service or supply is
2 furnished; or

3 “(ii) the electronic format for institu-
4 tional claims (and accompanying imple-
5 mentation guide) adopted as a standard by
6 the Secretary of Health and Human Serv-
7 ices pursuant to section 1173 of the Social
8 Security Act (42 U.S.C. 1320d–2); and

9 “(B) in the case of claim involving a health
10 care provider that is a physician or other indi-
11 vidual who is licensed, accredited, or certified
12 under State law to provide specified health care
13 services, is a properly completed billing instru-
14 ment that—

15 “(i) the Health Care Financing Ad-
16 ministration 1500 paper form, or its suc-
17 cessor, as adopted by the NUCC and fur-
18 ther defined by data element specifications
19 contained in the NUCC implementation
20 guide or, if such specifications are not
21 issued by the NUCC, the data element
22 specifications contained in the Medicare
23 Carriers Manual Part 4 (HCFA–Pub 14–
24 4) sections 2010.1 through 2010.4; or

1 (ii) the electronic format for profes-
2 sional claims (and accompanying imple-
3 mentation guide) adopted as a standard by
4 the Secretary of Health and Human Serv-
5 ices pursuant to section 1173 of the Social
6 Security Act (42 U.S.C. 1320d-2).

7 “(3) CONTESTED CLAIM.—The term ‘contested
8 claim’ means a claim for health care expenses that
9 is denied by a group health plan or health insurance
10 issuer during or after the benefit determination
11 process.

12 “(4) HEALTH CARE PROVIDER.—The term
13 ‘health care provider’ includes a physician or other
14 individual who is licensed, accredited, or certified
15 under State law to provide specified health care
16 services and who is operating with the scope of such
17 licensure, accreditation, or certification, as well as
18 an institution or other facility or agency that pro-
19 vides health care services and is licensed, accredited,
20 or certified to provide health care items and services
21 under applicable State law.

22 “(5) INCOMPLETE CLAIM.—The term ‘incom-
23 plete claim’ means a claim for health care expenses
24 that cannot be adjudicated because it fails to include

1 all of the required data elements necessary for adju-
2 dication.

3 “(6) NUBC.—The term ‘NUBC’ means the
4 National Uniform Billing Committee.

5 “(7) NUCC.—The term ‘NUCC’ means the Na-
6 tional Uniform Claim Committee.”.

7 **SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**
8 **ACT.**

9 (a) GROUP MARKET.—Subpart 2 of part A of title
10 XXVII of the Public Health Service Act (42 U.S.C.
11 300gg–4 et seq.) is amended by adding at the end the
12 following:

13 **“SEC. 2707. PROMPT PAYMENT OF HEALTH BENEFITS**
14 **CLAIMS.**

15 “(a) TIMEFRAME FOR PAYMENT OF COMPLETE
16 CLAIM.—A group health plan, and a health insurance
17 issuer offering group health insurance coverage in connec-
18 tion with a group health plan, shall pay all complete claims
19 and uncontested claims—

20 “(1) in the case of a claim that is submitted
21 electronically, within 14 days of the date on which
22 the claim is submitted; or

23 “(2) in the case of a claim that is not submitted
24 electronically, within 30 days of the date on which
25 the claim is submitted.

1 “(b) PROCEDURES INVOLVING SUBMITTED
2 CLAIMS.—

3 “(1) IN GENERAL.—Not later than 10 days
4 after the date on which a complete claim is sub-
5 mitted, a group health plan, and a health insurance
6 issuer offering group health insurance coverage in
7 connection with a group health plan, shall provide
8 the claimant with a notice that acknowledges receipt
9 of the claim by the plan or issuer. Such notice shall
10 be considered to have been provided on the date on
11 which the notice is mailed or electronically trans-
12 ferred.

13 “(2) CLAIM DEEMED TO BE COMPLETE.—A
14 claim is deemed to be a complete claim under this
15 section if the group health plan or health insurance
16 issuer involved does not provide notice to the claim-
17 ant of any deficiency in the claim within 10 days of
18 the date on which the claim is submitted.

19 “(3) INCOMPLETE CLAIMS.—

20 “(A) IN GENERAL.—If a group health plan
21 or health insurance issuer determines that a
22 claim for health care expenses is incomplete, the
23 plan or issuer shall, not later than the end of
24 the period described in paragraph (2), notify
25 the claimant of such determination. Such notifi-

1 cation shall specify all deficiencies in the claim
2 and shall list all additional information or docu-
3 ments necessary for the proper processing and
4 payment of the claim.

5 “(B) DETERMINATION AFTER SUBMISSION
6 OF ADDITIONAL INFORMATION.—A claim is
7 deemed to be a complete claim under this para-
8 graph if the group health plan or health insur-
9 ance issuer involved does not provide notice to
10 the claimant of any deficiency in the claim with-
11 in 10 days of the date on which the additional
12 information is received pursuant to subpara-
13 graph (A).

14 “(C) PAYMENT OF UNCONTESTED POR-
15 TION OF A CLAIM.—A group health plan or
16 health insurance issuer shall pay any
17 uncontested portion of a claim in accordance
18 with subsection (a).

19 “(4) OBLIGATION TO PAY.—A claim for health
20 care expenses that is not paid or contested by a
21 group health plan or health insurance issuer within
22 the timeframes set forth in this subsection shall be
23 deemed to be a complete claim and paid by the plan
24 or issuer in accordance with subsection (a).

1 “(c) DATE OF PAYMENT OF CLAIM.—Payment of a
2 complete claim under this section is considered to have
3 been made on the date on which full payment is received
4 by the health care provider.

5 “(d) INTEREST SCHEDULE.—

6 “(1) IN GENERAL.—With respect to a complete
7 claim, a group health plan or health insurance issuer
8 that fails to comply with subsection (a) shall pay the
9 claimant interest on the amount of such claim, from
10 the date on which such payment was due as provided
11 in this section, at the following rates:

12 “(A) 1½ percent per month from the 1st
13 day of nonpayment after payment is due
14 through the 15th day of such nonpayment.

15 “(B) 2 percent per month from the 16th
16 day of such nonpayment through the 45th day
17 of such nonpayment.

18 “(C) 2½ percent per month after the 46th
19 day of such nonpayment.

20 “(2) CONTESTED CLAIMS.—With respect to
21 claims for health care expenses that are contested by
22 the plan or issuer, once such claim is deemed com-
23 plete under subsection (b), the interest rate applica-
24 ble for noncompliance under this subsection shall
25 apply consistent with paragraphs (1) and (2).

1 “(e) PRIVATE RIGHT OF ACTION.—Nothing in this
2 section shall be construed to prohibit or limit a claim or
3 action not covered by the subject matter of this section
4 that any claimant has against a group health plan, or a
5 health insurance issuer.

6 “(f) ANTI-RETALIATION.—Consistent with applicable
7 Federal or State law, a group health plan or health insur-
8 ance issuer shall not retaliate against a claimant for exer-
9 cising a right of action under this section.

10 “(g) FINES AND PENALTIES.—

11 “(1) FINES.—

12 “(A) IN GENERAL.—If a group health plan
13 or health insurance issuer offering group health
14 insurance coverage willfully and knowingly vio-
15 lates this section or has a pattern of repeated
16 violations of this section, the Secretary shall im-
17 pose a fine not to exceed \$1,000 per claim for
18 each day a response is delinquent beyond the
19 date on which such response is required under
20 this section.

21 “(B) REPEATED VIOLATIONS.—If 3 sepa-
22 rate fines under subparagraph (A) are levied
23 within a 5-year period, the Secretary is author-
24 ized to impose a penalty in an amount not to
25 exceed \$10,000 per claim.

1 “(2) REMEDIAL ACTION PLAN.—Where it is es-
2 tablished that the group health plan or health insur-
3 ance issuer willfully and knowingly violated this sec-
4 tion or has a pattern of repeated violations, the Sec-
5 retary shall require the health plan or health insur-
6 ance issuer to—

7 “(A) submit a remedial action plan to the
8 Secretary; and

9 “(B) contact claimants regarding the
10 delays in the processing of claims and inform
11 claimants of steps being taken to improve such
12 delays.

13 “(h) DEFINITIONS.—In this section:

14 “(1) CLAIMANT.—The term ‘claimant’ means
15 an enrollee or health care provider submitting a
16 claim for payment of health care expenses.

17 “(2) COMPLETE CLAIM.—The term ‘complete
18 claim’ is a claim for payment of covered health care
19 expenses that—

20 “(A) in the case of a claim involving a
21 health care provider that is an institution or
22 other facility or agency that provides health
23 care services, is a properly completed billing in-
24 strument that consists of—

1 “(i) the Health Care Financing Ad-
2 ministration 1450 (UB-92) paper form, or
3 its successor, as adopted by the NUBC,
4 with data element usage consistent with
5 the usage prescribed in the UB-92 Na-
6 tional Uniform Billing Data Elements
7 Specification Manual, and, for claims sub-
8 mitted before October 1, 2002, any State-
9 designated data requirements that are de-
10 termined and approved by the State uni-
11 form billing committee of the State in
12 which the health care service or supply is
13 furnished; or

14 “(ii) the electronic format for institu-
15 tional claims (and accompanying imple-
16 mentation guide) adopted as a standard by
17 the Secretary of Health and Human Serv-
18 ices pursuant to section 1173 of the Social
19 Security Act (42 U.S.C. 1320d-2); and

20 “(B) in the case of claim involving a health
21 care provider that is a physician or other indi-
22 vidual who is licensed, accredited, or certified
23 under State law to provide specified health care
24 services, is a properly completed billing instru-
25 ment that—

1 “(i) the Health Care Financing Ad-
2 ministration 1500 paper form, or its suc-
3 cessor, as adopted by the NUCC and fur-
4 ther defined by data element specifications
5 contained in the NUCC implementation
6 guide or, if such specifications are not
7 issued by the NUCC, the data element
8 specifications contained in the Medicare
9 Carriers Manual Part 4 (HCFA–Pub 14–
10 4) sections 2010.1 through 2010.4; or

11 “(ii) the electronic format for profes-
12 sional claims (and accompanying imple-
13 mentation guide) adopted as a standard by
14 the Secretary of Health and Human Serv-
15 ices pursuant to section 1173 of the Social
16 Security Act (42 U.S.C. 1320d–2).

17 “(3) CONTESTED CLAIM.—The term ‘contested
18 claim’ means a claim for health care expenses that
19 is denied by a group health plan or health insurance
20 issuer during or after the benefit determination
21 process.

22 “(4) HEALTH CARE PROVIDER.—The term
23 ‘health care provider’ includes a physician or other
24 individual who is licensed, accredited, or certified
25 under State law to provide specified health care

1 services and who is operating with the scope of such
2 licensure, accreditation, or certification, as well as
3 an institution or other facility or agency that pro-
4 vides health care services and is licensed, accredited,
5 or certified to provide health care items and services
6 under applicable State law.

7 “(5) INCOMPLETE CLAIM.—The term ‘incom-
8 plete claim’ means a claim for health care expenses
9 that cannot be adjudicated because it fails to include
10 all of the required data elements necessary for adju-
11 dication.

12 “(6) NUBC.—The term ‘NUBC’ means the
13 National Uniform Billing Committee.

14 “(7) NUCC.—The term ‘NUCC’ means the Na-
15 tional Uniform Claim Committee.”.

16 (b) INDIVIDUAL MARKET.—Part B of title XXVII of
17 the Public Health Service Act (42 U.S.C. 300gg–41 et
18 seq.) is amended—

19 (1) by redesignating the first subpart 3 (relat-
20 ing to other requirements) as subpart 2; and

21 (2) by adding at the end of subpart 2 the fol-
22 lowing:

1 **“SEC. 2753. STANDARDS RELATING TO PROMPT PAYMENT**
2 **OF HEALTH BENEFITS CLAIMS.**

3 “The provisions of section 2707 shall apply to health
4 insurance coverage offered by a health insurance issuer
5 in the individual market in the same manner as they apply
6 to health insurance coverage offered by a health insurance
7 issuer in connection with a group health plan in the small
8 or large group market.”.

9 **SEC. 4. AMENDMENTS TO THE SOCIAL SECURITY ACT.**

10 (a) **MEDICARE.—**

11 (1) **MEDICARE ADVANTAGE PLANS.—**Section
12 1857(f) of the Social Security Act (42 U.S.C.
13 1395w–27(f)) is amended—

14 (A) in paragraph (1), by striking “con-
15 sistent with the provisions of sections
16 1816(c)(2) and 1842(c)(2)” and inserting “con-
17 sistent with the provisions of section 2707 of
18 the Public Health Service Act”; and

19 (B) in paragraph (2)—

20 (i) in the second sentence, by insert-
21 ing “and to reflect the amount of any fines
22 or penalties imposed pursuant to the provi-
23 sions of section 2707(g) of the Public
24 Health Service Act” before the period at
25 the end; and

1 (ii) by inserting before the second sen-
2 tence the following new sentence: “Pay-
3 ment of such amounts shall include any in-
4 terest due pursuant to the provisions of
5 section 2707(d) of the Public Health Serv-
6 ice Act.”.

7 (2) PRESCRIPTION DRUG PLANS.—Section
8 1860D–12(b)(3) of the Social Security Act (42
9 U.S.C.1395w–112(b)(3)) is amended—

10 (A) by redesignating subparagraphs (E)
11 and (F) as subparagraphs (F) and (G), respec-
12 tively; and

13 (B) by inserting after subparagraph (D)
14 the following new subparagraph:

15 “(E) PROMPT PAYMENT BY MEDICARE AD-
16 VANTAGE ORGANIZATION.—Section 1857(f).”.

17 (b) MEDICAID.—Section 1932(f) of the Social Secu-
18 rity Act (42 U.S.C. 1396u–2(f)) is amended by striking
19 “the claims payment procedures described in section
20 1902(a)(37)(A), unless the health care provider and the
21 organization agree to an alternate payment schedule” and
22 inserting “section 2707 of the Public Health Service Act”.

23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to plan years beginning after De-
25 cember 31, 2004.

1 **SEC. 5. PREEMPTION.**

2 The provisions of this Act shall not supersede any
3 contrary provision of State law if the provision of State
4 law imposes requirements, standards, or implementation
5 specifications that are equal to or more stringent than the
6 requirements, standards, or implementation specifications
7 imposed under this Act, and any such requirements,
8 standards, or implementation specifications under State
9 law that are equal to or more stringent than the require-
10 ments, standards, or implementation specifications under
11 this Act shall apply to group health plans and health in-
12 surance issuers as provided for under State law.

13 **SEC. 6. EFFECTIVE DATE.**

14 (a) IN GENERAL.—Except as provided in this section,
15 the amendments made by this Act shall apply with respect
16 to group health plans and health insurance issuers for
17 plan years beginning after December 31, 2004.

18 (b) SPECIAL RULE FOR COLLECTIVE BARGAINING
19 AGREEMENTS.—In the case of a group health plan main-
20 tained pursuant to one or more collective bargaining
21 agreements between employee representatives and one or
22 more employers ratified before the date of the enactment
23 of this Act, the amendments made by this Act shall not
24 apply to plan years beginning before the later of—

25 (1) the date on which the last of the collective
26 bargaining agreements relating to the plan termi-

1 nates (determined without regard to any extension
2 thereof agreed to after the date of the enactment of
3 this Act), or

4 (2) January 1, 2005.

5 For purposes of paragraph (1), any plan amendment made
6 pursuant to a collective bargaining agreement relating to
7 the plan which amends the plan solely to conform to any
8 requirement of the amendments made by this section shall
9 not be treated as a termination of such collective bar-
10 gaining agreement.

11 **SEC. 7. SEVERABILITY.**

12 If any provision of this Act, or an amendment made
13 by this Act, is held by a court to be invalid, such invalidity
14 shall not affect the remaining provisions of this Act, or
15 amendments made by this Act.

○