109TH CONGRESS
2D SESSION

S. 2551

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

IN THE SENATE OF THE UNITED STATES

APRIL 5, 2006

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

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A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Prompt Payment of Health Benefits Claims Act of 2006''.

SEC. 2. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

"SEC. 714. PROMPT PAYMENT OF HEALTH BENEFITS CLAIMS.

"(a) TIMEFRAME FOR PAYMENT OF CLEAN CLAIM.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall pay all clean claims and uncontested claims—

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

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

"(b) PROCEDURES INVOLVING SUBMITTED CLAIMS.—

"(1) IN GENERAL.—Not later than 10 days after the date on which a clean claim is submitted, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall provide the claimant with a notice that acknowledges receipt of the claim by the plan or issuer. Such notice shall be considered to have been provided on the date on

which the notice is mailed or electronically transferred.

''(2) CLAIM DEEMED TO BE CLEAN.—A claim is deemed to be a clean claim under this section if the group health plan or health insurance issuer involved does not provide notice to the claimant of any deficiency in the claim within 10 days of the date on which the claim is submitted.

''(3) CLAIM DETERMINED TO NOT BE A CLEAN CLAIM.—

''(A) IN GENERAL.—If a group health plan or health insurance issuer determines that a claim for health care expenses is not a clean claim, the plan or issuer shall, not later than the end of the period described in paragraph (2), notify the claimant of such determination. Such notification shall specify all deficiencies in the claim and shall list with specificity all additional information or documents necessary for the proper processing and payment of the claim.

''(B) DETERMINATION AFTER SUBMISSION OF ADDITIONAL INFORMATION.—A claim is deemed to be a clean claim under this paragraph if the group health plan or health insur-

ance issuer involved does not provide notice to the claimant of any deficiency in the claim within 10 days of the date on which additional information is received pursuant to subparagraph (A).

''(C) PAYMENT OF UNCONTESTED PORTION OF A CLAIM.—A group health plan or health insurance issuer shall pay any uncontested portion of a claim in accordance with subsection (a).

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

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

''(d) INTEREST SCHEDULE.—

''(1) IN GENERAL.—With respect to a clean claim, a group health plan or health insurance issuer that fails to comply with subsection (a) shall pay the claimant interest on the amount of such claim, from

the date on which such payment was due as provided in this section, at the following rates:

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

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

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

"(2) CONTESTED CLAIMS.—With respect to claims for health care expenses that are contested by the plan or issuer, once such claim is deemed clean under subsection (b), the interest rate applicable for noncompliance under this subsection shall apply consistent with paragraph (1).

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

"(f) ANTI-RETALIATION.—Consistent with applicable Federal or State law, a group health plan or health insurance issuer shall not retaliate against a claimant for exercising a right of action under this section.

''(g) FINES AND PENALTIES.—

''(1) FINES.—

''(A) IN GENERAL.—If a group health plan, or health insurance issuer offering group health insurance coverage, willfully and knowingly violates this section or has a pattern of repeated violations of this section, the Secretary shall impose a fine not to exceed $1,000 per claim for each day a response is delinquent beyond the date on which such response is required under this section.

''(B) REPEATED VIOLATIONS.—If 3 separate fines under subparagraph (A) are levied within a 5-year period, the Secretary is authorized to impose a penalty in an amount not to exceed $10,000 per claim.

''(2) REMEDIAL ACTION PLAN.—Where it is established that the group health plan or health insurance issuer willfully and knowingly violated this section or has a pattern of repeated violations, the Secretary shall require the group health plan or health insurance issuer to—

''(A) submit a remedial action plan to the Secretary; and

"(B) contact claimants regarding the delays in the processing of claims and inform claimants of steps being taken to improve such delays.

"(h) DEFINITIONS.—In this section:

"(1) CLAIMANT.—The term 'claimant' means a participant, beneficiary, pharmacy, or health care provider submitting a claim for payment of health care expenses.

"(2) CLEAN CLAIM.—The term 'clean claim' means a claim—

"(A) with respect to health care expenses for an individual who is covered under a group health plan on the date such expenses are incurred;

"(B) for such expenses that are covered under such plan at such time; and

"(C) that is submitted with all of the information requested by a group health plan or health insurance issuer offering group health insurance coverage in connection with a group health plan on the claim form or other instructions provided to the health care provider prior to submission of the claim.

''(3) CONTESTED CLAIM.—The term 'contested claim' means a claim for health care expenses that is denied by a group health plan or health insurance issuer during or after the benefit determination process.

''(4) HEALTH CARE PROVIDER.—The term 'health care provider' includes a physician or other individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification, as well as an institution or other facility or agency that provides health care services and is licensed, accredited, or certified to provide health care items and services under applicable State law.''.

SEC. 3. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

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

''SEC. 2707. PROMPT PAYMENT OF HEALTH BENEFITS CLAIMS.

''(a) TIMEFRAME FOR PAYMENT OF CLEAN CLAIM.—A group health plan, and a health insurance issuer offer-

ing group health insurance coverage in connection with a group health plan, shall pay all clean claims and uncontested claims—

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

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

''(b) PROCEDURES INVOLVING SUBMITTED CLAIMS.—

''(1) IN GENERAL.—Not later than 10 days after the date on which a clean claim is submitted, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall provide the claimant with a notice that acknowledges receipt of the claim by the plan or issuer. Such notice shall be considered to have been provided on the date on which the notice is mailed or electronically transferred.

''(2) CLAIM DEEMED TO BE A CLEAN CLAIM.—A claim is deemed to be a clean claim under this section if the group health plan or health insurance issuer involved does not provide notice to the claim-

ant of any deficiency in the claim within 10 days of the date on which the claim is submitted.

"(3) CLAIM DETERMINED TO NOT BE A CLEAN CLAIM.—

"(A) IN GENERAL.—If a group health plan or health insurance issuer determines that a claim for health care expenses is not clean, the plan or issuer shall, not later than the end of the period described in paragraph (2), notify the claimant of such determination. Such notification shall specify all deficiencies in the claim and shall list with specificity all additional information or documents necessary for the proper processing and payment of the claim.

"(B) DETERMINATION AFTER SUBMISSION OF ADDITIONAL INFORMATION.—A claim is deemed to be a clean claim under this paragraph if the group health plan or health insurance issuer involved does not provide notice to the claimant of any deficiency in the claim within 10 days of the date on which the additional information is received pursuant to subparagraph (A).

"(C) PAYMENT OF UNCONTESTED PORTION OF A CLAIM.—A group health plan or

health insurance issuer shall pay any uncontested portion of a claim in accordance with subsection (a).

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

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

''(d) INTEREST SCHEDULE.—

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

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

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

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

''(2) CONTESTED CLAIMS.—With respect to claims for health care expenses that are contested by the plan or issuer, once such claim is deemed clean under subsection (b), the interest rate applicable for noncompliance under this subsection shall apply consistent with paragraph (1).

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

''(f) ANTI-RETALIATION.—Consistent with applicable Federal or State law, a group health plan or health insurance issuer shall not retaliate against a claimant for exercising a right of action under this section.

''(g) FINES AND PENALTIES.—

''(1) FINES.—

''(A) IN GENERAL.—If a group health plan, or health insurance issuer offering group health insurance coverage, willfully and know-

ingly violates this section or has a pattern of repeated violations of this section, the Secretary shall impose a fine not to exceed $1,000 per claim for each day a response is delinquent beyond the date on which such response is required under this section.

''(B) REPEATED VIOLATIONS.—If 3 separate fines under subparagraph (A) are levied within a 5-year period, the Secretary is authorized to impose a penalty in an amount not to exceed $10,000 per claim.

''(2) REMEDIAL ACTION PLAN.—Where it is established that the group health plan or health insurance issuer willfully and knowingly violated this section or has a pattern of repeated violations, the Secretary shall require the health plan or health insurance issuer to—

''(A) submit a remedial action plan to the Secretary; and

''(B) contact claimants regarding the delays in the processing of claims and inform claimants of steps being taken to improve such delays.

''(h) DEFINITIONS.—In this section:

''(1) CLAIMANT.—The term 'claimant' means a participant, beneficiary, pharmacy, or health care provider submitting a claim for payment of health care expenses.

''(2) CLEAN CLAIM.—The term 'clean claim' means a claim—

''(A) with respect to health care expenses for an individual who is covered under a group health plan on the date such expenses are incurred;

''(B) for such expenses that are covered under such plan at such time; and

''(C) that is submitted with all of the information requested by a group health plan or health insurance issuer offering group health insurance coverage in connection with a group health plan on the claim form or other instructions provided to the health care provider prior to submission of the claim.

''(3) CONTESTED CLAIM.—The term 'contested claim' means a claim for health care expenses that is denied by a group health plan or health insurance issuer during or after the benefit determination process.

''(4) HEALTH CARE PROVIDER.—The term 'health care provider' includes a physician or other individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification, as well as an institution or other facility or agency that provides health care services and is licensed, accredited, or certified to provide health care items and services under applicable State law.''.

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

(1) by redesignating the first subpart 3 (relating to other requirements) as subpart 2; and

(2) by adding at the end of subpart 2 the following:

''SEC. 2753. STANDARDS RELATING TO PROMPT PAYMENT OF HEALTH BENEFITS CLAIMS.

''The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

SEC. 4. AMENDMENTS TO THE SOCIAL SECURITY ACT.

(a) PROMPT PAYMENT BY PRESCRIPTION DRUG PLANS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

''(4) PROMPT PAYMENT OF CLEAN CLAIMS.—

''(A) PROMPT PAYMENT.—

''(i) IN GENERAL.—Each contract entered into with a PDP sponsor under this section with respect to a prescription drug plan offered by such sponsor shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to all clean claims submitted under this part within the applicable number of calendar days after the date on which the claim is received.

''(ii) CLEAN CLAIM DEFINED.—In this paragraph, the term 'clean claim' means a claim—

''(I) with respect to health care expenses for an individual who is covered under a group health plan on the date such expenses are incurred;

"(II) for such expenses that are covered under such plan at such time; and

"(III) that is submitted with all of the information requested by a group health plan or health insurance issuer offering group health insurance coverage in connection with a group health plan on the claim form or other instructions provided to the health care provider prior to submission of the claim.

"(B) APPLICABLE NUMBER OF CALENDAR DAYS DEFINED.—In this paragraph, the term 'applicable number of calendar days' means—

"(i) with respect to claims submitted electronically, 14 days; and

"(ii) with respect to claims submitted otherwise, 30 days.

"(C) INTEREST SCHEDULE.—

"(i) IN GENERAL.—With respect to a clean claim, a PDP sponsor that fails to comply with subparagraph (A) shall pay the claimant interest on the amount of such claim, from the date on which such

payment was due as provided in this paragraph, at the following rates:

"(I) 1½ percent per month from the 1st day of nonpayment after payment is due through the 15th day of such nonpayment.

"(II) 2 percent per month from the 16th day of such nonpayment through the 45th day of such nonpayment.

"(III) 2½ percent per month after the 46th day of such nonpayment.

"(D) PROCEDURES INVOLVING CLAIMS.—

"(i) IN GENERAL.—A contract entered into with a PDP sponsor under this section with respect to a prescription drug plan offered by such sponsor shall provide that, not later than 10 days after the date on which a clean claim is submitted, the PDP sponsor shall provide the claimant with a notice that acknowledges receipt of the claim by such sponsor. Such notice shall be considered to have been provided

on the date on which the notice is mailed or electronically transferred.

''(ii) CLAIM DEEMED TO BE A CLEAN CLAIM.—A claim is deemed to be a clean claim if the PDP sponsor involved does not provide notice to the claimant of any deficiency in the claim within 10 days of the date on which the claim is submitted.

''(iii) CLAIM DETERMINED TO NOT BE A CLEAN CLAIM.—

''(I) IN GENERAL.—If a PDP sponsor determines that a submitted claim is not a clean claim, the PDP sponsor shall, not later than the end of the period described in clause (ii), notify the claimant of such determination. Such notification shall specify all defects or improprieties in the claim and shall list with specificity all additional information or documents necessary for the proper processing and payment of the claim.

''(II) DETERMINATION AFTER SUBMISSION OF ADDITIONAL INFORMATION.—A claim is deemed to be a

clean claim under this paragraph if the PDP sponsor involved does not provide notice to the claimant of any defect or impropriety in the claim within 10 days of the date on which additional information is received under subclause (I).

''(III) PAYMENT OF CLEAN PORTION OF A CLAIM.—A PDP sponsor shall, as appropriate, pay any portion of a claim that would be a clean claim but for a defect or impropriety in a separate portion of the claim in accordance with subparagraph (A).

''(iv) OBLIGATION TO PAY.—A claim submitted to a PDP sponsor that is not paid or contested by the provider within the applicable number of days (as defined in subparagraph (B)) shall be deemed to be a clean claim and shall be paid by the PDP sponsor in accordance with subparagraph (A).

''(v) DATE OF PAYMENT OF CLAIM.—Payment of a clean claim under such subparagraph is considered to have been made

on the date on which full payment is received by the provider.

''(E) PRIVATE RIGHT OF ACTION.—

''(i) IN GENERAL.—Nothing in this paragraph shall be construed to prohibit or limit a claim or action not covered by the subject matter of this section that any individual or organization has against a provider or a PDP sponsor.

''(ii) ANTI-RETALIATION.—Consistent with applicable Federal or State law, a PDP sponsor shall not retaliate against an individual or provider for exercising a right of action under this subparagraph.

''(F) FINES AND PENALTIES.—

''(i) FINES.—

''(I) IN GENERAL.—If a PDP sponsor willfully and knowingly violates this section or has a pattern of repeated violations of this section, the Secretary shall impose a fine not to exceed $1,000 per claim for each day a response is delinquent beyond the date on which such response is required under this paragraph.

''(II) REPEATED VIOLATIONS.—If 3 separate fines under subclause (I) are levied within a 5-year period, the Secretary is authorized to impose a penalty in an amount not to exceed $10,000 per claim.

''(ii) REMEDIAL ACTION PLAN.—Where it is established that the PDP sponsor willfully and knowingly violated this section or has a pattern of repeated violations, the Secretary shall require the PDP sponsor to—

''(I) submit a remedial action plan to the Secretary; and

''(II) contact claimants regarding the delays in the processing of claims and inform claimants of steps being taken to improve such delays.''.

(b) PROMPT PAYMENT BY MA-PD PLANS.—Section 1857(f) of the Social Security Act (42 U.S.C. 1395w–27) is amended by adding at the end the following new paragraph:

''(3) INCORPORATION OF CERTAIN PRESCRIPTION DRUG PLAN CONTRACT REQUIREMENTS.—The provisions of section 1860D–12(b)(4) shall apply to

contracts with a Medicare Advantage organization in the same manner as they apply to contracts with a PDP sponsor offering a prescription drug plan under part D.''.

(c) MEDICAID.—Section 1932(f) of the Social Security Act (42 U.S.C. 1396u–2(f)) is amended by striking ''the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the organization agree to an alternate payment schedule'' and inserting ''section 1860D–12(b)(4), in the same manner as the provisions of such section apply to a PDP sponsor offering a prescription drug plan under part D''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into or renewed on or after December 31, 2006.

SEC. 5. PREEMPTION.

The provisions of this Act shall not supersede any contrary provision of State law if the provision of State law imposes requirements, standards, or implementation specifications that are equal to or more stringent than the requirements, standards, or implementation specifications imposed under this Act, and any such requirements, standards, or implementation specifications under State law that are equal to or more stringent than the requirements, standards, or implementation specifications under

this Act shall apply to group health plans and health insurance issuers as provided for under State law.

SEC. 6. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 4 and subsection (b), the amendments made by this Act shall apply with respect to group health plans and health insurance issuers for plan years beginning after December 31, 2006.

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

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2007.

For purposes of paragraph (1), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of the amendments made by this section shall

not be treated as a termination of such collective bargaining agreement.

SEC. 7. SEVERABILITY.

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

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