Senate File 504 - Introduced

SENATE FILE 504
BY COMMITTEE ON COMMERCE

(SUCCESSOR TO SSB 1202)

A BILL FOR

An Act relating to timely submission of claims by health care providers to health insurers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 507B.4, subsection 3, paragraph p, Code 2019, is amended to read as follows:

p. Payment of interest. Failure of an insurer to pay interest at the rate of ten percent per annum on all health insurance claims that the insurer fails to timely accept and pay pursuant to section ~~507B.4A~~ 507B.04B, subsection 2, paragraph *"d"*. Interest shall accrue commencing on the thirty-first day after receipt of all properly completed proof of loss forms.

Sec. 2. Section 507B.4A, Code 2019, is amended by striking the section and inserting in lieu thereof the following:

507B.4A Duty to respond to inquiries.

1. A person shall promptly respond to an inquiry from the commissioner. A person's actions are deemed untimely under this section if the person fails to respond to an inquiry from the commissioner within thirty days of the receipt of the inquiry, unless good cause exists for delay.

2. Failure to respond to an inquiry from the commissioner pursuant to this section with such frequency as to indicate a general business practice shall subject the person to penalty under this chapter.

Sec. 3. NEW SECTION. **507B.04B Timely submission of claims and prompt payment of claims.**

1. *a.* For purposes of this section, unless the context otherwise requires:

(1) *"Facility"* means the same as defined in section 514J.102.

(2) *"Health care professional"* means the same as defined in section 514J.102.

(3) *"Health care provider"* or *"provider"* means a health care professional or a facility.

(4) *"Health care services"* means the same as defined in section 514J.102.

(5) *"Health insurer"* means an entity subject to the insurance laws and regulations of this state, or subject to

the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company offering sickness and accident plans under chapter 509, 514, or 514A, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

b. A health care provider shall have up to three hundred sixty-five calendar days after the date of provision of health care services to timely submit a claim to a health insurer for the health care services provided by the provider.

c. A health care provider shall have up to three hundred sixty-five calendar days from the date of last adjudication by a health insurer to resubmit a claim for adjustment of a paid claim, or for reconsideration of a denied claim.

d. A claim submitted by a health care provider shall not be paid by a health insurer if the claim is received by the health insurer two or more years from the date of provision of health care services by the health care provider.

e. This subsection shall not apply to Medicaid providers and Medicaid managed care organizations.

2. *a.* A health insurer shall either accept and pay a clean claim, or deny a clean claim.

b. For purposes of this subsection, "*clean claim*" means a properly completed paper or electronic billing instrument containing all reasonably necessary information that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.

c. The commissioner shall adopt rules establishing processes for timely adjudication and payment of claims by health insurers. The rules shall be consistent with the time frames

and other procedural standards for claims decisions by group health plans established by the United States department of labor pursuant to 29 C.F.R. pt. 2560 in effect on January 1, 2020.

d. Payment of a clean claim shall include interest at the rate of ten percent per annum when a health insurer, or an entity that administers or processes claims on behalf of the health insurer, fails to timely pay a claim.

e. This subsection shall not apply to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 4. Section 507B.6, subsection 1, Code 2019, is amended to read as follows:

1. Whenever the commissioner believes that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice whether or not defined in section 507B.4, ~~507B.4A~~ 507B.04B, or 507B.5 and that a proceeding by the commissioner in respect to such method of competition or unfair or deceptive act or practice would be in the public interest, the commissioner shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing on such charges to be held at a time and place fixed in the notice, which shall not be less than ten days after the date of the service of such notice.

Sec. 5. Section 507B.12, subsection 1, Code 2019, is amended to read as follows:

1. The commissioner may, after notice and hearing, promulgate reasonable rules, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by section 507B.4, ~~507B.4A~~ 507B.04B, or 507B.5, but the rules shall not enlarge upon or extend the provisions of such sections. Such rules shall be subject to review in accordance with chapter 17A.

Sec. 6. Section 514F.6, subsection 2, paragraph b, Code 2019, is amended to read as follows:

b. "*Clean claim*" means the same as defined in section ~~507B.4A~~ 507B.04B, subsection 2, paragraph "*b*".

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to the timely submission of claims by health care providers to health insurers. The bill defines "health insurer", "health care provider", and "health care services".

The bill provides that a health care provider shall have up to 365 days after the date of the provision of health care services to submit a claim to a health insurer. The provider has up to 365 days from the date of the last adjudication by a health insurer to resubmit a claim for adjustment or reconsideration. A claim submitted two or more years from the date of provision of health care services shall not be paid by an insurer. These provisions of the bill apply to all health insurers and health care providers except Medicaid providers and Medicaid managed care organizations.

The bill makes conforming changes.