Amendments

Insurance
May 9, 2000
2000-4414s
01/09 4468s

Amendment to HB 1240

Amend the title of the bill by replacing it with the following:

AN ACT requiring the department of health and human services and insurers to make prompt payments.

Amend the bill by replacing all after the enacting clause with the following:

1 New Section; Prompt Payment Required. Amend RSA 126-A by inserting after section 12 the following new section:

126-A:12-a Prompt Payment Required. The department shall pay health care providers, including dental providers, within 45 days of receipt of a clean claim for services rendered to medicaid recipients. For the purposes of this section "clean claim" means a claim for payment of covered health care expenses that is submitted to the department on the department's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the department's published filing requirements.

2 New Section; Prompt Payment Required. Amend RSA 415 by inserting after section 6-g the following new section:

415:6-h Prompt Payment Required.

I. Each insurer that issues or renews any individual policy of accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for services rendered by New Hampshire health care providers within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon receipt of a clean electronic claim. If the insurer is denying or pending the claim, the insurer shall have 15 calendar days upon receipt of the claim to notify the health care provider or certificate holder of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. The insurer's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published

procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements.

(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the insurer.

III. Any claim not paid within the time periods specified in paragraph I shall be deemed overdue. When a claim is overdue, the health care provider may notify the insurer in writing of the insurer's noncompliance with this section. If the insurer fails to pay the claim within 10 days of receiving the notice, then:

(a) The amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due; and

(b) The health care provider may recover from the insurer, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against an insurer for payment of the claim.

IV. Exceptions to the requirements of this section are as follows:

(a) No insurer shall be in violation of this section for a claim submitted by a health care provider if:

(1) Failure to comply is caused by a directive from a court or a federal or state agency;

(2) The insurer is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(3) The insurer's compliance is rendered impossible due to matters beyond the insurer's control which are not caused by such insurer.

(b) No insurer shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.

(c) No insurer shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review process.

V. The commissioner may assess an administrative fine against any insurer or may suspend or revoke the license or certificate of authority of any insurer after determining that the insurer has established a pattern of overdue payments and that the contemplated enforcement action would not promote the deterioration of the financial condition of an at-risk insurer. Such fine shall be up to $5,000 per violation, not to exceed $100,000.

3 New Section; Prompt Payment Required. Amend RSA 415 by inserting after section 18-j the following new section:

415:18-k Prompt Payment Required.

I. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for

services rendered by New Hampshire health care providers within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon receipt of a clean electronic claim. If the insurer is denying or pending the claim, the insurer shall have 15 calendar days upon receipt of the claim to notify the health care provider or certificate holder of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. The insurer's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements.

(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the insurer.

III. Any claim not paid within the time periods specified in paragraph I shall be deemed overdue. When a claim is overdue, the health care provider may notify the insurer in writing of the insurer's noncompliance with this section. If the insurer fails to pay the claim within 10 days of receiving the notice, then:

(a) The amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due; and

(b) The health care provider may recover from the insurer, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against an insurer for payment of the claim.

IV. Exceptions to the requirements of this section are as follows:

(a) No insurer shall be in violation of this section for a claim submitted by a health care provider if:

(1) Failure to comply is caused by a directive from a court or a federal or state agency;

(2) The insurer is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(3) The insurer's compliance is rendered impossible due to matters beyond the insurer's control which are not caused by such insurer.

(b) No insurer shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.

(c) No insurer shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external

review process.

V. The commissioner may assess an administrative fine against any insurer or may suspend or revoke the license or certificate of authority of any insurer after determining that the insurer has established a pattern of overdue payments and that the contemplated enforcement action would not promote the deterioration of the financial condition of an at-risk insurer. Such fine shall be up to $5,000 per violation, not to exceed $100,000.

4 New Section; Prompt Payment Required. Amend RSA 420-A by inserting after section 17-c the following new section:

420-A:17-d Prompt Payment Required.

I. Every health service corporation, and every other similar corporation licensed under the laws of another state that issues or renews any policy of individual or group blanket accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for services rendered by New Hampshire health care providers within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon receipt of a clean electronic claim. If the health service corporation is denying or pending the claim, the corporation shall have 15 calendar days upon receipt of the claim to notify the health care provider or subscriber of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. The corporation's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to a health service corporation on the corporation's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the corporation's published filing requirements.

(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the corporation.

III. Any claim not paid within the time periods specified in paragraph I shall be deemed overdue. When a claim is overdue, the health care provider may notify the health service corporation in writing of the health service corporation's noncompliance with this section. If the health service corporation fails to pay the claim within 10 days of receiving the notice, then:

(a) The amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due; and

(b) The health care provider may recover from the health service corporation, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against an health service corporation for payment of the claim.

IV. Exceptions to the requirements of this section are as follows:

(a) No health service corporation shall be in violation of this section for a claim submitted by a health care provider if:

(1) Failure to comply is caused by a directive from a court or a federal or state agency;

(2) The corporation is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(3) The corporation's compliance is rendered impossible due to matters beyond the corporation's control which are not caused by such corporation.

(b) No health service corporation shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.

(c) No health service corporation shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review process.

V. The commissioner may assess an administrative fine against any health service corporation or may suspend or revoke the license or certificate of authority of any health service corporation after determining that the health service corporation has established a pattern of overdue payments and that the contemplated enforcement action would not promote the deterioration of the financial condition of an at-risk insurer. Such fine shall be up to $5,000 per violation, not to exceed $100,000.

5 New Section; Prompt Payment Required. Amend RSA 420-J by inserting after section 8 the following new section:

420-J:8-a Prompt Payment Required.

I. Health carriers issuing health benefit plans subject to this chapter shall pay claims submitted by health care providers for services rendered in New Hampshire to covered persons within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon receipt of a clean electronic claim. If the health carrier is denying or pending the claim, the carrier shall have 15 calendar days upon receipt of the claim to notify the health care provider or covered person of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. The health carrier's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to a health carrier on the carrier's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements.

(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the health carrier.

III. Any claim not paid within the time periods specified in paragraph I shall be deemed overdue. When a claim is overdue, the health care provider may notify the health carrier in writing of the carrier's noncompliance with this section. If the health carrier fails to pay the claim within 10 days of receiving the notice, then:

(a) The amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due; and

(b) The health care provider may recover from the carrier, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against an carrier for payment of the claim.

IV. Exceptions to the requirements of this section are as follows:

(a) No health carrier shall be in violation of this section for a claim submitted by a health care provider if:

(1) Failure to comply is caused by a directive from a court or a federal or state agency;

(2) The health carrier is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or

(3) The carrier's compliance is rendered impossible due to matters beyond the carrier's control which are not caused by such carrier.

(b) No health carrier shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.

(c) No health carrier shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review determination pursuant to RSA 420-J:5, or RSA 420-J:5-a-e.

V. The commissioner may assess an administrative fine against any health carrier or may suspend or revoke the license or certificate of authority of any health carrier after determining that the health carrier has established a pattern of overdue payments and that the contemplated enforcement action would not promote the deterioration of the financial condition of an at-risk insurer. Such fine shall be up to $5,000 per violation, not to exceed $100,000.

6 Effective Date. This act shall take effect January 1, 2001.

2000-4414s

AMENDED ANALYSIS

This bill requires the department of health and human services to pay its dental and other health care providers for services rendered to medicaid recipients promptly.

This bill also requires insurers offering health benefit plans to pay health care providers in a timely manner.

Committee Minutes

Date: **April 18, 2000**
Time: **9:15**
Room: **103-SH**

The Senate Committee on **Insurance** held a hearing on the following:

HB 1240 **(2nd New Title) requiring the department of health and human services and insurers to make prompt payments.**

Members of Committee present: ***Senator Wheeler***
Senator Francoeur
Senator Eaton
Senator Fraser
Senator Hollingworth
Sen. J. King
Sen. McCarley
Senator Squires

The Chair, **Senator Katie Wheeler,** opened the hearing by calling on the prime sponsor of the bill, Representative Crosby, as the first speaker.

Representative Toni Crosby, District 20: **House Bill 1240** came to me at about the same time I guess **Senate Bill 383** came to **Senator Pignatelli.** Little did I know that we were filing exactly the same legislation.

It seemed like a good thing and I believe that the compromises have been worked out. I have copies of an amendment – which is to **Senate Bill 383**, but it could also be crossed out and be **1240.**

I would like **Janet Monahan** and **Yvonne Nanasi** to explain it to you since they are the ones that crafted it.

Senator Katherine W. Wheeler, D. 21: Thank you. I guess that my only question is – as far as the process goes, if these two bills become identical, I presume you would want one of them to pass.

Representative Crosby: Absolutely, I don't care if it is mine or hers. I would just like a good law in place.

Senator Katherine W. Wheeler, D. 21: Thank you. We will deal with it as best we can.

I am going to call on **Janet Monahan** and **Yvonne Nanasi** to explain the amendment. We just have a question or so of what's going on right now.

Senate Bill 383 is having its hearing in the **House Commerce Committee** this morning. And, at that time....Pardon our ignorance for not remembering everything that is happening in our lives, but did the Senate adopt this amendment to **Senate Bill 383**?

Yvonne Nanasi, Anthem – Blue Cross/Blue Shield: No. You all adopted an amendment to **383** which does not include some of the items that we have since "fine tuned" into this amendment.

Senator Katherine W. Wheeler, D. 21: So, this is the amendment that....The amendment that you're presenting to us now for **1240** is the amendment that will also be presented to the **Commerce Committee** this morning for **Senate Bill 383**?

Yvonne Nanasi: Yes.

Senator Katherine W. Wheeler, D. 21: Thank you, very much.

Carry on.

Janet Monahan, NH Medical Society: The Senate hearing on **383**...That was in **Senate Public Institutions**. **Senator Squires** asked **Yvonne** and myself and others to try to work out some agreement. We did work out...We're partway there on the first go around. And, we've since been meeting with **Tom Quarles** from **Etna** and **Lisa McGunnigle** from the **Hospital Association** and some people from **MGMA (Medical Group Managers Association)** and **Alex** from the **Insurance Department**.

We came up with the language that's in front of you today. ***(SEE ATTACHMENT #1).***

It retains **45 days** for a clean paper claim and **15 days** for a clean electronic claim – which I believe is the same as what passed in **383** out of the Senate.

The penalties, I believe, are the same – **1.5%** interest payment per month. And, there are attorneys' fees and the Department has the ability to fine if there's a pattern.

The language that we finalized over the last few weeks is really just fine tuning. So, it's clearer, but the basic number of days and the fine stayed the same.

Yvonne Nanasi: Some of the things that you will see that are (perhaps) a little different than what was in **383** that we worked on very diligently and came to agreement over, are things such as under the **first paragraph** that starts out, *"each insurer that issues or renew....."*

In the second line, we've added the words, *"for its insured persons"* and *"for services rendered by New Hampshire health care providers...."* That's an addition and something that we talked about and we thought was dropped out of the first amendment.

What this does....For **Anthem Blue Cross/Blue Shield**, we process claims for **Blue Cross/Blue Shield** plans in **California, Nevada**....Any place that an insured from that state might be here and incur our service. For example, **California** is responsible to pay that claim, not us. We merely process it.

So, this wording using insured allows that to continue to happen. **California** basically pays that claim so that does not fall under (inaudible) prompt payment requirements. It takes a longer time.

Our **New Hampshire** health care providers....We felt that the providers within the state are those that basically do the prompt payment. Providers from out of state....We get claims from states like **Texas** and **New Mexico** and may require more time in processing and probably should not be within the boundaries of this.

The sentence that was added to the last of this paragraph.....It starts out, *"this section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment."* This is a fine tuning of the sentence that wasn't in the amendment as you all passed it out.

We worked with the **Insurance Department** on the wording of this for a long time. What it functions to do is that contracts with providers that are (how shall we say)...They're paid on a periodic basis and not a claims basis. Some of the hospitals we even will front money up to and it's a draw down on their claims.

So, that would not understandably come under the statute.

So, that just gives you a feel of how we fine tuned some of this. We believe that **Anthem Blue Cross/Blue Shield** – that this timeline is attainable for us by **1/1/01**.

Janet Monahan: **Paragraph III** – bottom of the page.....You see a lot of crossing out over to the next page. That was just basically re-wording that entire paragraph.

What it basically does is the provider is not entitled to receive interest or reasonable attorney fees unless they notify the insurer that they are, in fact, late. That's to make sure that a claim didn't literally "fall through the cracks" – which has happened on occasion.

Senator James W. Squires, D. 12: In **126-A:12-a**, it says, *"the department shall pay health care providers..."* Well, I was talking to an administrator of a small rural hospital preparing for their annual "rite of spring".....Eight percent of their bills is Medicaid. She knows that she isn't going to get it in a timely fashion. When you say that the *"department shall...."* But, what happens if they don't!

Yvonne Nanasi: You're absolutely correct, but it's not in my area of expertise. I would just comment that the other sections of the bill that apply to insurers, carry significant penalties as well as what we call "cure periods," and process. And, that is the incentive for us to, in a sense, comply with the statute.

Senator James W. Squires, D. 12: On the **first page** of the amendment – **126-A:12-a**..... *"the department shall pay health care providers....."* That's clear.

On the **second page**, we go down to **paragraph V**... *"the commissioner may assess an administrative fine against any insurer....."*

Janet Monahan: That isn't a section that we negotiated.

Senator James W. Squires, D. 12: That raises the question as to who's the insurer? Is it the Department or is it someone else? So, that I thought I would point out here that this bill – which is certainly laudable, allows the state to follow a different set of payments than it's requiring of private services. I just want somebody to explain.

Senator Katherine W. Wheeler, D. 21: We'll call on **Alex Feldvebel** to answer that.

Senator Fraser?

Senator Leo W. Fraser, Jr., D. 4: **Yvonne**, what percentage of admit claims is electronic and what percentage is paper?

Yvonne Nanasi: Oh, gosh. I had that in the previous testimony....Let me just get out a "ball park" figure.....I know that a – I would say a good **sixty five** to **seventy five percent** are **electronic** at this point in time. There are some facilities – which were brought out during our negotiations such as the freestanding surgical center facilities – who submit their claims on paper still because they submit separate forms. It's easier for them to do that. They aren't set up to do electronic, plus we have supervisors in rural sections that do not pay us....we don't deal with them electronically.

We would like, of course, to move electronically. It's not a perfect system yet. But, for the majority, it's electronic.

Senator Katherine W. Wheeler, D. 21: Thank you.'

Alex Feldvebel?

Alex Feldvebel, Department of Insurance: On this issue of that first section as applied to the **Medicaid Program**, the penalty provision that you see starting on **page 2 – Roman V** – referring to the insurance commissioner, would not apply to the **Medicaid Program**.

They're in two different sections of the RSA's and **Medicaid** is not an insurer. It doesn't collect premiums and it doesn't set risks. It's not licensed by the **Insurance Department**.

So, the word "insurer" in **RSA 415** and **420** – as it appears, it's just the penalty provision as applied to licensed insurers – which has a specific definition of the Insurance statute.

I think there is a question whether....I'm concerned about this **Medicaid** provision that we haven't had input in this process from the **Department of Health and Human Services** on this issue. I think some attention should be paid to it.

The way it would be enforced, I would think, would be that providers....If this became law with **Medicaid** provisions, providers who were due payments that were overdue according to this new law, could file a lawsuit for injunctive or equitable relief. I think that would be the primary enforcement mechanism here.

I'm noticing that this section referring to **Medicaid** doesn't mention that it is for "clean claims,".....

Senator Katherine W. Wheeler, D. 21: What page, **Alex**.

Alex Feldvebel: The very **first page – section 1**.. *"the department shall pay..."* That section of the RSA's deals with the **Department of Health and Human Services**. I think that there are some issues around that section in the bill.

Senator Caroline McCarley, D. 6: **Alex**, I don't know if you were there for the testimony for **383**, but would you believe that at the time, **Mr. Fredyma** was there and we had someone come testify about a serious missed time frame for payments – which **Mr. Fredyma** took up with that individual later.

But, I thought that Jim had come in and indicated that for the most part....I thought that we got some testimony from the Department on it. I followed up later in terms of if that payment had indeed been cleaned up. It was my understanding that it all had been taken care of. The **Health Care Association** had assured me that indeed, it had been followed up.

I think that you're suggesting that perhaps we should have someone from the Department come in.....

Alex Feldvebel: I guess that's already happened.

Senator Caroline McCarley, D. 6: Well, they did on that part. Beyond that, the issue of penalties and payments and the follow up was not done. But, certainly, they came in indicating that this was something that would work.....(inaudible).

Senator Leo W. Fraser, Jr., D. 4: **Alex**, who tracks the **Medicaid Program** as far as promise of payment?

Alex Feldvebel: Well, major parties in interest are the providers. You know, hospitals, nursing homes, doctors..

Senator Leo W. Fraser, Jr., D. 4: I understand that but, I'm trying to get a hand on what are they doing today? Would they be in trouble if this bill passed?

Alex Feldvebel: I don't know. I don't know what the status quo is today. I know that historically, **Medicaid** payments were (inaudible) to hospitals and major providers and it was a budget balancing measure, basically.

My understanding is that doesn't happen anymore. So, it could easily be (inaudible) for current practice.

Senator Caroline McCarley, D. 6: I would suggest that we should get the Department here because in fairness to **Mr. Feldvebel**, they would be able to answer the questions.

Senator Beverly A. Hollingworth, D. 23: Are we going to duplicate on this **House Bill 383**? Is that what you're point is, or are you planning to hold this until action on **383** is taken?

Senator Katherine W. Wheeler, D. 21: When **Representative Crosby** introduced the bill, she indicated that the goal is to have **Senate Bill 383** and **House Bill 1240** be identical. Then, someone can decide which one should pass. I mean, we can pass both or we could pass one.

But, in either case, I don't think we should hold an executive session on this bill today. I think we should make sure that things go well in the **House Commerce Committee.**

Would this committee want to hear more of this and invite the Department in to talk to us?

Senator James W. Squires, D. 12: I'm more interested in inviting the providers specifically.....I think we're getting enormous concerns here about rural hospitals who in some cases, rely heavily on **Medicaid**....What I would like to hear from them is what do they think of their accounts receivable.

Senator Katherine W. Wheeler, D. 21: We can certainly recess this hearing and invite them to come and talk to us.

Is there anyone else who wishes to testify right now on **House Bill 1240**? Then, as I understand the committee, we think it's an important topic, so we want to hear from the providers. So, we will recess the hearing.

Hearing adjourned at 9:35 a.m.

Respectfully submitted,
Linda Brosseau, secretary/Rosalie Brooks Patch, transcriber

#1

#6

DOI Draft
April 5, 2000

Amendment to SB 383

Amend the bill to read as follows:

1 New Section; Prompt Payment Required. Amend RSA 126-A by inserting after section 12 the following new section:

126-A:12-a Prompt Payment Required. The department shall pay health care providers, including dental providers, within 45 days of receipt of a claim or bill for services rendered to medicaid recipients.

2 New Section; Prompt Payment Required. Amend RSA 415 by inserting after section 8-6-g the following new section:

415:~~8-a~~6-h Prompt Payment Required.

I. Each insurer that issues or renews any individual policy of accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for services rendered by New Hampshire health care providers ~~or certificate holders~~ within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon receipt of a clean electronic claim ~~or as otherwise stipulated in the provider and insurer contract~~. If the insurer is denying or pending the claim, the insurer shall have 15 calendar days upon receipt of the claim to notify the health care provider or certificate holder of the reason for denying or pending the claim and what, if any, additional information is required to process the claim.~~; provided, however, that t~~The insurer's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements.

(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the insurer.

III. ~~Notwithstanding any provision of law to the contrary, no penalties shall apply until the health care provider has notified the insurer in writing of the insurer's noncompliance with this section and the carrier fails to pay the claim within 10 days thereafter. Any claim not paid within the above time periods or in accordance with~~

~~contract provisions shall be deemed overdue. When the insurer fails to pay a claim when due or according to contract provisions, the amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due. Reasonable attorneys' fees for advising and representing a health care provider in a successful action against an insurer for payment of the claim shall be recoverable by the provider from the insurer upon a judicial finding of bad faith. The commissioner may assess a fine to any insurer after determining that the insurer has established a pattern of overdue payments; provided, that such fine shall be up to $5,000 per violation and shall not exceed $100,000.~~ Any claim not paid within the time periods specified in paragraph I shall be deemed overdue. When a claim is overdue, the health care provider may notify the insurer in writing of the insurer's noncompliance with this section. If the insurer fails to pay the claim within 10 days of receiving the notice, then: (1) the amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due, and (2) the health care provider may recover from the insurer, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against an insurer for payment of the claim.

IV. ~~Notwithstanding the provisions~~Exceptions to the requirements of this section:

(a) No insurer shall be in violation of this section for a claim submitted by a health care provider if failure to comply is caused by a directive from a court or a federal or state agency or if the insurer's compliance is rendered impossible due to matters beyond the insurer's control which are not caused by such insurer.

(b) No insurer shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.

(c) No insurer shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review process.

V. The commissioner may assess an administrative fine against any insurer or may suspend or revoke the license or certificate of authority of any insurer after determining that the insurer has established a pattern of overdue payments. Such fine shall be up to $5,000 per violation, not to exceed $100,000.

3 New Section; Prompt Payment Required. Amend RSA 415 by inserting after section 18-~~b~~j the following new section:

415:18-~~bb~~k Prompt Payment Required.

I. Each insurer that issues or renews any policy of group or blanket accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for services rendered by New Hampshire health care providers ~~or certificate holders~~ within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon

receipt of a clean electronic claim ~~or as otherwise stipulated in the provider and insurer contract~~. If the insurer is denying or pending the claim, the insurer shall have 15 calendar days upon receipt of the claim to notify the health care provider or certificate holder of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. ~~; provided, however, that t~~The insurer's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the insurer's published filing requirements.

(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the insurer.

III. ~~Notwithstanding any provision of law to the contrary, no penalties shall apply until the health care provider has notified the insurer in writing of the insurer's noncompliance with this section and the insurer fails to pay the claim within 10 days thereafter. Any claim not paid within the above time periods or in accordance with contract provisions shall be deemed overdue. When the insurer fails to pay a claim when due or according to contract provisions, the amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due. Reasonable attorneys' fees for advising and representing a health care provider in a successful action against an insurer for payment of the claim shall be recoverable by the provider from the insurer upon a judicial finding of bad faith. The commissioner may assess a fine to any insurer after determining that the insurer has established a pattern of overdue payments; provided, that such fine shall be up to $5,000 per violation and shall not exceed $100,000.~~ Any claim not paid within the time periods specified in paragraph I shall be deemed overdue. When a claim is overdue, the health care provider may notify the insurer in writing of the insurer's noncompliance with this section. If the insurer fails to pay the claim within 10 days of receiving the notice, then: (1) the amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due, and (2) the health care provider may recover from the insurer, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against an insurer for payment of the claim.

IV. ~~Notwithstanding the provisions~~Exceptions to the requirements of this section:

(a) No insurer shall be in violation of this section for a claim submitted by a health care provider if failure to comply is caused by a directive from a court or a federal or

state agency or if the insurer's compliance is rendered impossible due to matters beyond the insurer's control which are not caused by such insurer.

(b) No insurer shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.

(c) No insurer shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review process.

V. The commissioner may assess an administrative fine against any insurer or may suspend or revoke the license or certificate of authority of any insurer after determining that the insurer has established a pattern of overdue payments. Such fine shall be up to $5,000 per violation, not to exceed $100,000.

4 New Section; Prompt Payment Required. Amend RSA 420-A by inserting after section ~~9~~ 17-c the following new section:

420-A:~~9-a~~17-d Prompt Payment Required.

I. Every health service corporation, and every other similar corporation licensed under the laws of another state that issues or renews any policy of individual or group blanket accident or health insurance providing benefits for medical or hospital expenses for its insured persons shall pay for services rendered by New Hampshire health care providers ~~or subscribers~~ within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon receipt of a clean electronic claim ~~or as otherwise stipulated in the provider and corporation contract~~. If the health service corporation is denying or pending the claim, the corporation shall have 15 calendar days upon receipt of the claim to notify the health care provider or subscriber of the reason for denying or pending the claim and what, if any, additional information is required to process the claim. ~~; provided, however, that t~~The corporation's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to a health service corporation on the corporation's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the corporation's published filing requirements.

(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the corporation.

III. ~~Notwithstanding any provision of law to the contrary, no penalties shall apply until the health care provider has notified the health service corporation in writing of the corporation's noncompliance with this section and the corporation fails to pay the claim within 10 days thereafter. Any claim not paid within the above time periods or in accordance with contract provisions shall be deemed overdue. When the health service corporation fails to pay a claim when due or according to contract provisions, the amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due. Reasonable attorneys' fees for advising and representing a health care provider in a successful action against a corporation for payment of the claim shall be recoverable by the provider from the corporation upon a judicial finding of bad faith. The commissioner may assess a fine to any health service corporation after determining that the corporation has established a pattern of overdue payments; provided, that such fine shall be up to $5,000 per violation and shall not exceed $100,000.~~ Any claim not paid within the time periods specified in paragraph I shall be deemed overdue. When a claim is overdue, the health care provider may notify the health service corporation in writing of the health service corporation's noncompliance with this section. If the health service corporation fails to pay the claim within 10 days of receiving the notice, then: (1) the amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due, and (2) the health care provider may recover from the health service corporation, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against a health service corporation for payment of the claim.

IV. ~~Notwithstanding the provisions~~Exceptions to the requirements of this section:

(a) No health service corporation shall be in violation of this section for a claim submitted by a health care provider if failure to comply is caused by a directive from a court or a federal or state agency or if the corporation's compliance is rendered impossible due to matters beyond the corporation's control which are not caused by such corporation.

(b) No health service corporation shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.

(c) No health service corporation shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review process.

V. The commissioner may assess an administrative fine against any health service corporation or may suspend or revoke the license or certificate of authority of any health service corporation after determining that the health service corporation has established a pattern of overdue payments. Such fine shall be up to $5,000 per violation, not to exceed $100,000.

5 New Section; Prompt Payment Required. Amend RSA 420-J by inserting after section 8 the following new section:

420-J:8-a Prompt Payment Required.

I. Health carriers issuing health benefit plans subject to this chapter shall pay claims submitted by health care providers for services rendered in New Hampshire to covered persons within 45 calendar days upon receipt of a clean written claim or 15 calendar days upon receipt of a clean electronic claim ~~or as otherwise stipulated in the provider and health carrier contract~~. If the health carrier is denying or pending the claim, the carrier shall have 15 calendar days upon receipt of the claim to notify the health care provider ~~or covered person~~ of the reason for denying or pending the claim and what, if any, additional information is required to process the claim.~~; provided, however, that t~~The health carrier's failure to comply with the time limits in this section shall not have the effect of requiring coverage for an otherwise non-covered claim. This section shall only apply to payments made on a claims basis and shall not apply to capitation or other forms of periodic payment.

II. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to a health carrier on the carrier's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements.

(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the health carrier.

III. ~~Notwithstanding RSA 420-J:14, no penalties shall apply until the health care provider has notified the health carrier in writing of the carrier's noncompliance with this section and the carrier fails to pay the claim within 10 days thereafter. Any claim not paid within the above time periods or in accordance with contract provisions shall be deemed overdue. When the health carrier fails to pay a claim when due or according to contract provisions, the amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due. Reasonable attorneys' fees for advising and representing a health care provider in a successful action against a health carrier for payment of the claim shall be recoverable by the provider from the health carrier upon a judicial finding of bad faith. The commissioner may assess a fine to any health carrier after determining that the carrier has established a pattern of overdue payments; provided, that such fine shall be up to $5,000 per violation and shall not exceed $100,000.~~ Any claim not paid within the time periods specified in paragraph I shall be deemed overdue. When a claim is overdue, the health care provider may notify the health carrier in writing of the carrier's noncompliance with this section. If the health carrier fails to pay the claim within 10 days of receiving the notice, then: (1) the amount of the overdue claim shall include an interest payment of 1.5 percent per month

beginning from the date the payment was due, and (2) the health care provider may recover from the carrier, upon a judicial finding of bad faith, reasonable attorney's fees for advising and representing a health care provider in a successful action against a carrier for payment of the claim.

IV. ~~Notwithstanding the provisions~~Exceptions to the requirements of this section:

(a) No health carrier shall be in violation of this section for a claim submitted by a health care provider if failure to comply is caused by a directive from a court or a federal or state agency or if the carrier's compliance is rendered impossible due to matters beyond the carrier's control which are not caused by such carrier.

(b) No health carrier shall be in violation of this section for any claim submitted more than 90 days after the service was rendered.

(c) No health carrier shall be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review determination pursuant to RSA 420-J:5, or RSA 420-J:5-a-e.

V. The commissioner may assess an administrative fine against any health carrier or may suspend or revoke the license or certificate of authority of any health carrier after determining that the carrier has established a pattern of overdue payments. Such fine shall be up to $5,000 per violation, not to exceed $100,000.

6 Effective Date. This act shall take effect January 1, 2001.

Doc #1

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Anthem.

Senate Insurance Committee
4/18/2000
HB1240: Prompt payment by health insurers for provider claims

Over the past four months, Anthem BCBSNH has met several times with the NH Medical Society, representatives from provider practice groups, and the Department of Insurance to discuss how to reasonable resolve the concerns involved in the payment of provider claims.

Anthem BCBSNH senior management staff that have responsibility for provider contracting and claims processing participated in these very detailed discussions about how to best fashion legislation that could be implemented by the company and meet the needs of the providers.

Anthem BCBSNH asks that you accept the amendment to HB 1240 that is being proposed. The amendment represents good faith negotiation on behalf of the parties and is our best effort to achieve a compromise on this bill.

Anthem BCBSNH believes that the framework for payment of provider claims that is embodied in this proposed amendment is achievable by the effective date (1/1/2001). It will take an investment of company resources on our part to achieve this goal. Nevertheless, this proposal is much more reasonable and attainable than the original bill and it addresses several of the concerns we enumerated in our initial testimony.

We ask that you adopt this amendment and would appreciate providing you any information necessary to achieve that goal.

An independent licensee of the Blue Cross and Blue Shield Association.
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Date: **April 25, 2000**
Time: **9:25 a.m.**
Room: **103 - State House**

The Senate Committee on **Insurance** held a hearing on the following:

HB 1240 **(2nd New Title) requiring the department of health and human services and insurers to make prompt payments.**

Members of Committee present:

Senator Wheeler
Senator Francoeur
Senator Eaton
Senator Fraser
Senator Hollingworth
Sen. J. King
Sen. McCarley
Senator Squires

RECESSED HEARING FROM APRIL 18, 2000

The Chair, **Senator Katie Wheeler,** opened the hearing.

Senator Katherine W. Wheeler, D. 21: I will re-open the hearing on **House Bill 1240** – which we recessed last week and we have invited speakers to come and make some presentations to us today.

Lisa McGunnigle has signed up from the **Hospital Association** in favor, and **Jim Fredyma** has signed up from **Health and Human Services** in opposition. Is there anyone else who wishes to help us in our deliberation on this bill? *(No response).*

We will now have Lisa McGunnigle as our first speaker.

Lisa McGunnigle, New Hampshire Hospital Association: In response to your questions last week regarding prompt payment and specifically, how delayed Medicaid payments affect hospitals and most specifically, rural hospitals, I went back and touched base with several members of the Association and Friday, I met with the **Rural Health Coalition** – which meets once a month at the **Clinic New Hampshire**.

At the **Rural Health Coalition**, the CEO's of the rural hospitals did express a great deal of concern over delayed payments at the end of the state budget cycle – which is of huge concern to them. But, on the other hand, they did state that for about 10 months out of the year, they don't have a problem with delayed payments and they are very concerned about using up the **Department of Health and Human Services** budget to pay fines. They would prefer that the budget is used to pay for medical care and not for fines.

So, in balance, they were not for or against applying the prompt pay law to the state Medicaid payments. They are happy with how the payments come through for most of the year. They would very much like to see something done about the last couple of months of the year to see if they could rectify that situation. But, they absolutely do not want to see Medicaid moneys used to pay fines as opposed to paying for care.

Senator Gary R. Francoeur, D. 14: ***(Senator Francoeur's question was inaudible).***

Lisa McGunnigle: Currently, there are many long standing accounts that are still out with **Harvard Pilgrim**. My understanding of this bill is that it would not be retroactive. It would not apply to those problems in the past with any carrier. And, hospitals are all in favor of this prompt pay bill as it applies to the insurance carriers. But, it would rectify that situation.

Senator Gary R. Francoeur, D. 14: ***(Senator Francoeur's question was inaudible).***

Lisa McGunnigle: In this bill, the commissioner has discretion over whether to apply fines or not. She has the choice of applying up to **$5,000**

per incident and no more than **$100,000**. And, she does have the leeway to take into consideration situations such as receiverships.

Senator Katherine W. Wheeler, D. 21: Thank you.

James Fredyma?

James Fredyma, Department of Health and Human Services – Representing Commissioner Shumway: If what we're talking about today is the proposed amendment to **Senate Bill 383** – which adds some significant language effecting the Department's responsibility to pay claims within 45 days and also includes language around interest payments and attorney's fees, I would tell you that the Department is opposed to this legislation – primarily because we think it is both unnecessary and given that we are heading into a time of budget reductions and hiring freezes, you're setting up potentially expectations that we're going to have to make payments of interest in attorney's fees or something that is outside of our control {sic}.

We will end up spending our time documenting the degree to which things are outside of our control and incurring substantial amounts of legal expense to do that.

Given that we're dealing with budget deficits and children's services and Medicaid, having to spend money on attorney's fees and the like, just makes the situation that much worse.

I had understood that there was language originally in **Senate Bill 383** that simply required us to make payments within 45 days. I believe that we were recorded as being in favor of that language because it was more of a statement of intent that we would do everything that we could to comply. But, this amendment proposes a significant change to that – including interest and attorney's fees and we're opposed to the legislation.

Senator Caroline McCarley, D. 6: If I could look at the amendment to **Senate Bill 383**....I recall that you all testified in support of it as well.

But, apparently, under the very first section, it says, *"the department shall pay healthcare providers including dental providers within 45 days of*

receipt……" Could you point to me where the problem is that has now resulted in your not being able to support the legislation?

Senator Katherine W. Wheeler, D. 21: It seems to me that questions arose about *"the commissioner may assess administrative fines against any insurer……"* We asked **Alex Feldvebel** and he said that Medicaid was not considered an insurer – which would mean that the commissioners – those who assess fines….would not be applying to the HHS……

As I see it, the only specific reference to the Department is in that 45 day…….

James Fredyma: I'm working off something that had been represented to me last week as having been submitted to the Senate as a proposed amendment to **Senate Bill 383**. Now, I have something that is a little different and I haven't had a chance to read this yet.

Senator Katherine W. Wheeler, D. 21: If the insurer – as made reference to in the amendment – has no application to **HHS** and if the only thing we're talking about is the 45 day payment period, is there a concern that you have with that 45 days?

James Fredyma: At the risk of speaking without having had the chance to read this…..which I am a little concerned about doing…..If it is only the provision in the very first paragraph that says, *"the department shall pay health care providers including dental providers within 45 days of receipt of a claim or bill for services rendered to Medicaid recipients,"* that seems very similar to the original language of the original bill. And, if that's all there is, that's what I believe we supported.

If it is anything else, then I would want to have the opportunity to look at it and be sure that we're not making a commitment to do something here that we can't deliver on.

Senator Katherine W. Wheeler, D. 21: Fine. We won't vote on it right now. We'll make sure that we figure that out.

Senator King?

Senator John A. King, D. 18: What is the reason for the delay? What has to happen so there won't be that delay?

James Fredyma: There are a number of factors that enter into it and everyone of these situations has been different. The most frequent cause for us of payment delays is when we simply run out of money and we're waiting for the legislature to appropriate more funds.

The current budget is a good example of that in that we – in provider payments, for example, had testified that we needed approximately **$166 million dollars** and the legislature only appropriated **$159 million**. So, we knew heading into the year that we were **$6 million dollars** short.

We have – through a number of revenue enhancement activities, solved that problem for state fiscal year 2000 and we expect to have some additional revenues to solve that problem in 2001. So, we don't anticipate at this point, payment delays or pending claims in the **Medicaid Program** for either this year or next year.

In years past, we had a significant problem in **1996**. We ran out of money in February. For those of you in the legislature in **1996**, you may recall it wasn't until the end of **April** that the legislature actually appropriated sufficient funds to allow us to continue making payments to children's services providers.

That clearly is outside of our control.

Other things that occur can be the implementation of a new system. You may recall in 1995, we had assurances from **EDS** that their new Medicaid claims payment system was ready to go. We turned it on July 1st and unfortunately, it was not ready to go. We ended up with litigation – ultimately settled to some degree to the state's favor. That didn't necessarily help the providers who experienced 4 or 5 or 6 months delay in payments.

We have also had other situations with systems implementations – transmitting client eligibility from the eligibility system to the Medicaid system and also, to deal with the changes from **Senate Bill 409** about liability of the counties for home and community based care.

Senator Katherine W. Wheeler, D. 21: Thank you.

John Poirier, NH Health Care Association: I am here this morning to speak in favor of this bill – including the amendment.

The claims processing that I'm here to talk about today is, for the most part, about **$175 million dollars** that is paid through the **Medicaid Program** to long term care facilities in the state.

The Medicaid reimbursement for nursing facilities at this point, reimburses about **90%** of what allowable costs are. So, when you look at a nursing facility, if it costs **$5 million dollars** to run a nursing facility for a year, for the Medicaid residents in those facilities, the state is paying about **$.90** on the dollar. Those costs have to be captured someplace else or reimbursed someplace else - most typically, with the mix of private pay residents in those facilities.

When we talk about the delay in payment, I bring up the **$.90** on the dollar because if you are talking about 45, 60, 75, 90 days of delay in paying **90%** of what the actual costs are, obviously, there is an increased strain on the cash flow of those facilities.

As many of you know, there are about **20%** of the nursing facilities in the **State of New Hampshire** today that are operating under **Chapter 11** bankruptcy. Some of them are doing better in bankruptcy than they had prior to filing bankruptcy – from a strict cash flow perspective. But, it is a crisis out there and that coupled with the staffing crisis on direct care workers, paints a pretty bleak picture that we need to have the funding to be able to insure that there are people in these facilities that are taking care of the residents that are our responsibility.

The sentiments echoed by the **Hospital Association** – I guess I would like to reiterate. There typically is a delay at the end of the fiscal years when funding or appropriations are starting to be fully expended and the main part of the problem as I see it at least, is at the end of the fiscal year when whatever was appropriated is almost fully expended. That's when the "clean claim" portion of this bill, I think, would have the most significant effect.

For the most part, claims that are clean during the fiscal year are being worked on in conjunction with the Department and the providers and they do

tend to get resolved. Sometimes, more timely than others. But, the main thrust is at the end of the fiscal year.

I guess I would like to point out that this bill is only speaking to "clean claims." Now, that's a claim where all of the paperwork has properly been submitted, all of the documentation of the family members or where the residents are required to bring to the Department, have been fully processed and are clean in the system.

There's a whole other issue of how do you get all of that paperwork and how do you get to the point of a clean claim – which this bill doesn't address. I would just say that if we are only talking about clean claims – which this bill very clearly is only talking about, that this would be a bill that the legislature should support.

I would be happy to answer any questions you might have.

Senator Caroline McCarley, D. 6: Do you have a copy of another amendment? Apparently,.....Maybe we could get a discussion on the same amendment.

John Poirier: I have a copy of an amendment that says, ***"Proposed Amendment For Senate Bill 383. (SEE ATTACHMENT A).*** In your discussion earlier, I briefly went through this and I didn't see the section that you were talking about with regard to interest...

Senator Katherine W. Wheeler, D. 21: Does yours say at the top....I know it doesn't, because it's not the same format as ours. Does it say, "**DOI Draft – April 5' 2000**?"

John Poirier: No.

Senator Beverly A. Hollingworth, D. 23: I think that might be the problem.

David Minnis, Lobbyist: I think I can explain the confusion. I submitted this amendment to the **House Commerce Committee** when they held their public hearing on **Senate Bill 383**. My concern was that there was no definition in the front section that dealt with **Health and Human Services**. There's no definition of "clean claim" or "electronic claim." So, I simply

took some of the language that the Senate had already passed in **Senate Bill 383** and reworded it slightly and put it in the front section there. I did not submit, unfortunately, that amendment to this committee when it was dealing with **House Bill 1240** because the House committee was at the same time that the Senate committee met. I was in the House at that time, so I missed your first hearing because I was at the hearing for **Senate Bill 383** with **Senator Pignatelli**.

So, I submitted that amendment to the House committee.

Senator Katherine W. Wheeler, D. 21: The amendment that was presented to us had the support of **Yvonne Nanasi** and **Janet Monahan**. They appeared together and presented the amendment.

David Minnis: That's correct.

Senator Katherine W. Wheeler, D. 21: They worked on this amendment?

David Minnis: Well, they have not because their amendment only applied to the insurance companies whereas this amendment only applied to the **Department of Health and Human Services.**

Senator Katherine W. Wheeler, D. 21: All right. Are there any more questions for **Mr. Poirier**? *(No response).*

I will now call on Mr. Minnis.

David Minnis: I don't really have anything to add to this discussion other than to answer some questions that might relate to the amendment that I submitted. It was simply to try and make sure that the same definitions applied to the **Department of Health and Human Services** as applied to the insurance providers.

But, the bill as written, only had that one sentence in there with respect to **Health and Human Services** and it just said they'll pay claims within 45 days. But, there was no "teeth" to it. There was no enforcement to it. There was no incentive for the Department to do that. So, my attempt was simply to parallel the language in the insurance section.

Senator Katherine W. Wheeler, D. 21: Does your amendment then require.....*(The remainder of Senator Wheeler's question was inaudible).*

David Minnis: No, it does not require them to pay fines. It required them to pay an interest penalty – which is the same language that's in the bottom part of the bill. But, it's the **1.5%** per month interest. But, that's only on clean claims. That's not on a claim that's submitted that there's a problem with or the Department questions whether the provider is over billing for certain services of certain procedures. Anything that the Department has a problem with, is not a clean claim. And, that can take 45, 90, 180 days. If there is a problem with it, that exempts it from this amendment. It's only "clean claims."

Senator James W. Squires, D. 12: Is it my understanding, **David**, that **Medicare** pays interest on clean claims that are not paid within a certain amount of time?

David Minnis: I would have to turn to my client on that one.

John (?): In some instances, it does. Yes.

Senator James W. Squires, D. 12: There are federal guidelines and penalties. That is, in the form of interest.

David Minnis: If I could quickly add....If the Department has problems with the attorney fees, I'm certainly willing to drop that. I mean, that's not the intent here. The intent here was to....If the claim is clean, get the payment out the door.

I also would point out that if you look at the bottom part of the amendment – the *"notwithstanding the provisions of this section,"* they are exempt from this if they run out of money. If, at the end of the year the legislature doesn't provide them with enough money and they can't pay the claims, then they are exempt from this section of the law. That's in **(A)** – where it says, *"not in violation submitted if the failure is caused by a directive from a court or if the department's compliance is rendered impossible due to matters beyond the department's control."*

So, if it doesn't have enough money, then obviously, that's something that's beyond its control and it's not responsible for it.

Senator John A. King, D. 18: Is the Department part of the state?

David Minnis: Yes.

Senator John A. King, D. 18: If the Department runs out of available funds, okay. But, this here is very big. We budgeted. We don't give them enough. If we fund them properly..

David Minnis: That's correct. What my attempt here was to say is, if the legislature doesn't fund the Department properly in order to pay its claims, the Department cannot be held responsible. It would be the legislature who would be held responsible.

I would be willing to reword that if you would like me to do that.

Senator John A. King, D. 18: I think that's the biggest problem.

Senator Leo W. Fraser, Jr., D. 4: What is the track record of **Health and Human Services** today?

David Minnis: Well, I'm not the person that would best answer that, Senator. I don't submit claims. I think the Department is here and they could probably answer that and my client is here. I think they try hard. I also think that there are areas that could be improved if some of the payments don't get made on time or within a reasonable time period. But, I think they try very hard to do them.

Again, we're talking about the clean claims. Whenever there is a contested claim, that puts it into a different ball park. But, I think you're better off asking somebody else that question.

Senator Katherine W. Wheeler, D. 21: Palmer Jones, did you wish to speak?

Palmer Jones, Representing the NH Medical Society: There's just 3 points that I would like to make.

First, is to follow-up with what **Lisa McGunnigle** said. As representing the physician providers, there is – at the end of the year, always an issue because

the state does run out of money. I think that physicians have learned how to sort of work with it because when the money is then allocated, they do get paid for it. They also realize that it's an economic situation, so it's not a major problem. They're used to it, but there is a delay – the last 2 months traditionally – until money is authorized so that they can be paid. So, that's an issue.

The reference to your question, Senator, regarding the working on this amendment, this has been worked on and worked on and worked on by Yvonne and Janet and they had a nicely crafted document that I thought everybody was in total agreement with. The question about how it should apply to federal or state is another issue.

David's amendment would need a lot of work – from my quick reading of it. I guess what you're suggesting is that we go "back to the table" again to try to see if we can rework it. But, it does create some issues. I can understand the association's problems and their concerns, but the issue is that this is completely different than some of the agreements that have been worked out so far.

So, I think we need time to get this identical throughout.

Senator Katherine W. Wheeler, D. 21: Thank you.

Senator Squires, since you wanted some more input on this, I would appreciate your advice.

Senator James W. Squires, D. 12: In listening to the testimony, I'm struck by what seems to me an obvious (inaudible). If a company came and said that they were going to be delayed because they had a systems problem, they get an interest charge. If the **State of New Hampshire** comes and says they have a systems problem, nothing happens.

If a company runs out of....Let's say a major...**Cabletron**, for example. The company suddenly sees a major decline in their revenues and they can't make payments on behalf of their employees. Yet, what happens with the state.....We excuse it because we didn't give enough money. With a private company, we say, you have to pay an interest.

From the point of view of the provider, it's somewhat irrelevant. They need the dollars. It's particularly true in the smaller hospitals in the poorer communities where you have a high percentage of **Medicare**, but also a substantial percentage of **Medicaid**.

There was an interesting chart passed around yesterday which we all saw showing that of the **26 hospitals** in **New Hampshire**, 16 are either breaking even or losing money. Only 10 are operating in the "green."

So, there are practical realities here and I suppose we'll do what we have to do. But, it is not right. The **State of New Hampshire** should have the same obligations to make provider payments – as it imposes – on a private company.

Senator Katherine W. Wheeler, D. 21: Well, recognizing the amazing amount of work that has already been done in order to have both the **Medical Society** and **Anthem Blue Cross/Blue Shield** come forward as one on this and understanding that the legislature really is concerned about prompt payment, I would ask you to make one more effort and involve the **Department of Health and Human Services** as well as the **Insurance Department** and if you could bring forward something that is officially drafted.....

Senator Beverly A. Hollingworth, D. 23: ***(The beginning of Senator Hollingworth's statement was inaudible)***.....The thing that stuck in my mind was they felt that **Medicare** money should be used for care and not a fine. We have to fund a budget. We know that. It's the responsibility of Finance and the Senate that we fund the departments appropriately so that they can have their money so that the last two months of the year they don't run out of money. That's our problem.

It's not the departments' fault. So, we're punishing the departments for our failure. I mean, that's what it comes down to. So, I have a real problem with why.....I understand what Jim's saying. I just don't see how....Other then, we fund the Department adequately. That's how we resolve this. I'm hoping that they can go back and find something that's the "magic bullet." I don't see how they can other than the magic bullet being that we fund appropriately, our departments, so that they can pay their bills.

Senator Katherine W. Wheeler, D. 21: Well, I'm not suggesting that you need to change anything. I just want that discussion to take place with the Department and also the Insurance Department and whatever we decide, I would like to go with something that looks like an amendment so that we will all understand what we're voting on.

Palmer Jones: We will try....I mean, we did see this for the first time this morning, so we will try our best to.....

Senator Katherine W. Wheeler, D. 21: I'm talking about the original one, too. I mean, I really feel uncomfortable voting on something that looks like that.

Palmer Jones: I'm just the messenger.

Senator Katherine W. Wheeler, D. 21: Maybe you won't change a single word in it. But, this gives us more time to think about it and we will vote next week on it.

Senator Beverly A. Hollingworth, D. 23: If they need to have a legislator to be able to do the drafting with **OLS**,.....I know that **Alex** is extremely good at drafting. I've had many years experience with him.

Senator Leo W. Fraser, Jr., D. 4: **Yvonne Nanasi** testified last week that **85%** of the claims going into **Anthem** today are by electronic transfer.

Palmer Jones: Actually, it's probably even a little higher.

Senator Leo W. Fraser, Jr., D. 4: Does that percentage hold true so far as the **Department of Health and Human Services** is concerned....

Palmer Jones: I can't answer specifically on that. I know that **Medicaid** pays electronically. I assume the record is pretty good in that particular area.

I just want to make one comment and that is that **Medicare** is actually the best payer and the quickest payer of all. I wish everybody could pay as quickly and as promptly and cleanly as **Medicare** does. So, if we can look at that as sort of a guide, that will help.

Senator Katherine W. Wheeler, D. 21: Thank you very much, **Palmer**. I am now going to close the hearing on **House Bill 1240** and we will have the executive session probably next week. I appreciate all of you coming to testify.

Hearing adjourned at 10:17 a.m.

Respectfully submitted,

Linda Brosseau, Secretary/Rosalie Brooks Patch, Transcriber

A

I. Proposed Amendment to SB 383

Amend Section 1 of the bill by replacing it with the following:

1 New Section; Prompt Payment Required. Amend RSA 126-A by inserting after section 12 the following new section:

126-A:12-a Prompt Payment Required.

I. The department shall pay health care providers, including dental providers, within 45 days of receipt of a clean claim ~~or bill~~ for services rendered to Medicaid recipients unless otherwise stipulated in the provider contract.

II. If the department is denying or pending the claim, the department shall have 30 calendar days upon receipt of the claim to notify the health care provider of the reason for denying or pending the claim and what, if any, additional information is required to process the claim.

III. In this section:

(a) "Clean claim" means a claim for payment of covered health care expenses that is submitted to the department on the department's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the department's published filing requirements.

~~(b) "Electronic claim" means the transmission of data for purposes of payment of covered health care services in an electronic data format specified by the department.~~

IV. Notwithstanding any provision of law to the contrary, no penalties shall apply until the health care provider has notified the department in writing of the department's noncompliance with this section and the department fails to pay the clean claim within 14 days thereafter. Any clean claim not paid within the above time periods or in accordance with contract provisions shall be deemed overdue. When the department fails to pay a clean claim when due or according to contract provisions, the amount of the overdue claim shall include an interest payment of 1.5 percent per month beginning from the date the payment was due. ~~Reasonable attorneys' fees for advising and representing a health care provider in a successful action against the department for payment of the claim shall be recoverable by the provider from the department upon a judicial finding of bad faith.~~

V. Notwithstanding the provisions of this section:

(a) The department shall not be in violation of this section for a clean claim submitted by a health care provider if failure to comply is caused by a directive from a court or a federal or state agency or if the department's compliance is rendered impossible due to matters beyond the department's control which are not caused by the department, such as, but not limited to, a lack of sufficient appropriations from the legislature, contractor or fiscal agent performance problems, or state employee hiring freeze.

(b) The department shall not be in violation of this section for any claim submitted 90 days after the service was rendered.

(c) The department shall not be in violation of this section while the claim is pending due to a fraud investigation that has been reported to a state or federal agency, or an internal or external review process.

Speakers

SENATE INSURARNCE COMMITTEE

Date **April 18, 2000** Time **9:15am** Public Hearing on **HB1240**

Appearing in **FAVOR**: *(Please print)* *Please check box at left to speak.*

Speaking?	*Name*	*Address*	*Representing*
☐			
☒	Janet Monahan	7 N-State St. Concord	NH Medical Society
☐	Carol A Workman	194 Pleasant St Concord	Concord Otolaryngology
☒	Yvonne Manari		Anthem BCBSNH
☑	Toni Crosby		Merrimack 20
☑	Alex Feldvebel		DOT
☑	Russell Tom Alley		NH Podiatric Medical Assn
☐	GREGORY SMITH	15 N Main St, Concord	N.H Psychology Assn
☐			
☐			

Appearing in **OPPOSITION**: *(Please Print)* *Please check box at left to speak.*

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SENATE INSURARNCE COMMITTEE

Date April 25, 2000 Time 9:10am Public Hearing on HB1240

Appearing in FAVOR: (Please print) Please check box at left to speak.

Speaking?	Name	Address	Representing
☐	Russell MacCleery	19 Concord St 03234 Chichester	NH Podiatric Assn
☑	Lisa McCunnigle	125 Airport Rd	NH Hospital Assoc
☒	John Poirier	226-4900	NH Health Care
☐			
☐			
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Appearing in OPPOSITION: (Please Print) Please check box at left to speak.

☒	Jim Fredyma	NH DHHS	271-4333
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Committee Report

9:15 am 4/18
9:25 am 4/25

Date: April 18 and 25, 2000 Time: {

The Senate Committee on Insurance held its hearing in Room 103 - SH, Concord, New Hampshire.

BILL NO.: HB 1240 TITLE: (2nd New Title) requiring the department of health and human services and insurers to make prompt payments.

Members of the Committee present:

Senator Wheeler
Senator Blaisdell
Senator Francoeur
Senator Fraser
Senator Hollingworth
Sen. J. King
Sen. McCarley
Senator Squires

Those appearing in favor:

Name and Address	Representing
See Attached.	

Those appearing in opposition:

Name and Address	Representing
See Attached.	

REPORT OF THE COMMITTEE:

- ☐ Ought to Pass
- ☒ Ought to Pass w/ Amendment
- ☐ Inexpedient to Legislate
- ☐ Interim Study
- ☐ Continued Hearing
- ☐ Postponed Hearing

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date:

THE COMMITTEE ON Insurance

to which was referred House Bill 1240

AN ACT (New Title) requiring insurers to make prompt payments.

VOTE: 8-0

2000-4365s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Leo W. Fraser, Jr.
For the Committee

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date:

THE COMMITTEE ON Insurance

to which was referred House Bill 1240

AN ACT (New Title) requiring insurers to make prompt payments.

VOTE: 8-0

2000-4468s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Leo W. Fraser, Jr.
For the Committee

|HB1240 Docket

Bill Title: (2nd New Title) requiring the department of health and human services and insurers to make prompt payments.

Date	Body	Description
1/5/2000	H	Introduced and ref to Commerce; HJ5, p92
1/5/2000	H	Copy to Chairman on 12/22/1999
1/5/2000	H	Hearing Feb 8 10:00 RM302,LOB
2/22/2000	H	Subcom Work Session Mar 8 9:30 RM302,LOB
3/9/2000	H	Maj Report OTP/AM for Mar 23 (vote 19-0;CC)
3/9/2000	H	Prop Comm Am{3720}(New Title); HC23, p690-693
3/23/2000	H	Passed with Am; HJ26, p799-801 + 851
3/23/2000	S	Introduced and Ref. to Insurance; SJ 7, Pg.232
4/11/2000	S	Hearing April 18, Room 103, SH, 9:40 a.m.; SC22
4/13/2000	S	=TIME CHANGE= Hearing April 18, Room 103, SH, 9:15; SC23
4/19/2000	S	Hearing =CONTINUED= April 25, Room 103, SH, 9:10 a.m.; SC24
4/19/2000	S	For Purpose of hearing from Invited speakers
5/10/2000	S	Committee Report Ought to Pass with Amendment{4468}[New Title], 05/11/2000, SC28, Pg.21-25
5/11/2000	S	Committee Report Ought to Pass with Amendment {4468} {New Title}, AA, Refered to Finance Rule #24
5/17/2000	S	SJ 14, Pg.372-376
5/17/2000	S	Committee Report Ought to Pass,05/18/00; SC30
5/18/2000	S	Committee Report Ought to Pass; MA, VV; SJ 15, Pg.412
5/18/2000	S	Sen. F. King offered a Floor Amendment {4517}{New Title}, RC 11Y - 12N, AF; SJ 15, Pg.412-413
5/18/2000	S	Sen. Fraser offered a Floor Amendment {4568}{New Title}, (Sen. Fraser withdrew floor amendment)
5/18/2000	S	OT3rdg; MA, VV; SJ 15, Pg.413-416
5/18/2000	H	House Conc with Sen Am, Rep Hunt MA 2/3VV; HJ46, p1484
5/31/2000	S	Enrolled Bill Am {4762}, Adopted; SJ 16, Pg.599
5/31/2000	H	Enrolled Am{4762}, Adopted; HJ48, p1548
5/31/2000	H	Enrolled; HJ48, p1548
5/31/2000	S	Enrolled Bill; SJ 16, Pg.626
6/12/2000	H	Signed by the Governor on 6/12/2000 Eff: 1/1/2001 Chap: 0274

Docket Abbreviations