

108TH CONGRESS  
2D SESSION

# S. 2308

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

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IN THE SENATE OF THE UNITED STATES

APRIL 8, 2004

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

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## A BILL

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

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

3 **SECTION 1. SHORT TITLE.**

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

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

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

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

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

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

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

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

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

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

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

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

9 “(3) INCOMPLETE CLAIMS.—

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

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

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

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

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

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

19 “(d) INTEREST SCHEDULE.—

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

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

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

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

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

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

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

24          “(g) FINES AND PENALTIES.—

25                 “(1) FINES.—

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

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

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

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

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

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

3 “(h) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19           “(3) INCOMPLETE CLAIMS.—

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

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

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

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

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

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

5       “(d) INTEREST SCHEDULE.—

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

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

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

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

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

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

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

10       “(g) FINES AND PENALTIES.—

11               “(1) FINES.—

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

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

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

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

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

13           “(h) DEFINITIONS.—In this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (a) **MEDICARE.—**

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

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

19 (B) in paragraph (2)—

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

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

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

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

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

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

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

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

1 **SEC. 5. PREEMPTION.**

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

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

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

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

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

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

4 (2) January 1, 2005.

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

11 **SEC. 7. SEVERABILITY.**

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

○