AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

107TH CONGRESS
1ST SESSION

S. 1616

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

IN THE SENATE OF THE UNITED STATES

NOVEMBER 1, 2001

Mr. TORRICELLI (for himself and Mr. CORZINE) introduced the following bill; which was read twice and referred to the Committee on Finance

---

A BILL

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

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

SECTION 1. INTEREST ON LATE PAYMENTS OF CLEAN CLAIMS.

(a) REQUIREMENT.—

(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group health insurance coverage fails to provide payment of a clean claim (or provides partial payment on such claim) on or before the applicable number of calendar days established for purposes of payment of clean claims

under section 1842(c)(2) of the Social Security Act (42 U.S.C. 1395u(c)(2))—

(A) the payment (or unpaid portion of the payment) shall be overdue; and

(B) interest shall be paid on the overdue payment (or unpaid portion) to the provider, participant, beneficiary, or enrollee to which the payment is due in accordance with the requirements set forth in paragraph (2).

(2) INTEREST REQUIREMENTS.—

(A) SIMPLE INTEREST.—Interest on an overdue payment (including an unpaid portion of a payment) shall accrue at the rate of 18 percent per year.

(B) COMMENCEMENT.—Interest on an overdue payment (or unpaid portion) shall begin to accrue on the date that is 15 days after the date on which all information and documentation required to process the claim is received by the plan or issuer.

(C) PAYMENT.—Interest on an overdue payment (or unpaid portion) shall be—

(i) included with the payment due on the clean claim; or

(ii) paid within 14 days of the payment of the clean claim.

(b) ARBITRATION.—The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall develop an arbitration process under which a participant, beneficiary, or enrollee and a group health plan or health insurance issuer may obtain an independent determination with respect to a claim for an overdue payment and interest under subsection (a).

(c) FEDERAL CAUSE OF ACTION.—Notwithstanding any other provision of law, upon the termination of the arbitration process under subsection (b) with respect to an overdue payment and interest under subsection (a), an action seeking to recover such payment and interest may be brought in the district court of the United States for the judicial district in which the provider, participant, beneficiary, or enrollee to which the payment and interest are due resides.

(d) THIRD PARTY CONTRACTORS.—The requirements of this section shall apply to a group health plan or health insurance issuer regardless of whether the plan or issuer contracts with a third party for the administration and payment of claims under the plan or coverage.

(e) DEFINITION OF CLEAN CLAIM.—

(1) IN GENERAL.—In this section, the term ''clean claim'' means a claim submitted for health care services or supplies that meets the following requirements:

(A) The claim is for a service or supply covered by the group health plan or the health insurance coverage.

(B) The claim is submitted with all the information requested by the plan or issuer on the claim form or in other instructions distributed to the provider, participant, beneficiary, or enrollee.

(C) The participant, beneficiary, or enrollee to whom the service or supply was provided was covered under the group health plan or health insurance coverage on the date of service.

(D) The plan or issuer does not reasonably believe that the claim has been submitted fraudulently.

(E) The claim does not require special treatment.

(2) DEFINITION OF SPECIAL TREATMENT.—For purposes of paragraph (1)(E), the term ''special treatment'' means that—

(A) unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications; and

(B) the circumstances requiring such processing are documented in the claim file.

(3) OTHER DEFINITIONS.—In this section, the terms ''group health plan'' and ''health insurance issuer'' shall have the meanings given such terms under section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

○