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March 29, 2016

Chairman John Frullo
Insurance Committee, Texas House of Representative
Texas Capitol, Room E2.150
Austin, Texas 78701

RE: Written testimony for March 30, 2016, hearing on Interim Charge No. 3: Evaluate the statutory penalty calculations under Texas's prompt payment laws regarding health care claims.

Dear Chairman Frullo:

Texans for Lawsuit Reform Foundation has published a paper comparing Texas's prompt payment of claims statutes to similar statutes in other jurisdictions. We believe the paper addresses your Committee's Interim Charge No. 3. The paper is available at TLRFoundation.com. Additionally, eleven copies of *An Interstate Comparison of Healthcare Prompt-Pay Laws* are included with this letter.

Please consider the enclosed copies of the Foundation's paper as TLR's written testimony on Interim Charge No. 3. This written testimony is being submitted by TLR in lieu of giving oral testimony on March 30, 2016.

Sincerely,

E. Lee Parsley
Outside Counsel

An Interstate Comparison of Healthcare Prompt-Pay Laws

THIS PAPER PROVIDES AN OVERVIEW OF TEXAS'S HEALTHCARE PROMPT-PAY STATUTES AND COMPARES TEXAS'S STATUTES TO SIMILAR STATUTES IN OTHER STATES.

TEXANS FOR LAWSUIT REFORM FOUNDATION

January 31, 2016

Texans for Lawsuit Reform Foundation is a nonprofit research organization interested in providing objective analysis and effective solutions to address the challenges presented by the Texas civil justice system. The Foundation's publications do not necessarily reflect the opinions of its sponsors or of Texans for Lawsuit Reform.

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An Interstate Comparison of Healthcare Prompt-Pay Laws

TEXANS FOR LAWSUIT REFORM FOUNDATION

January 31, 2016

I. Introduction

All fifty states and the District of Columbia have "prompt-pay" statutes applicable in the healthcare context.[1] Essentially, these prompt-pay statutes require health insurance companies to pay claims submitted by healthcare providers (*e.g.*, physicians and hospitals) within set time limits, or face penalties and other sanctions. These prompt-pay laws vary significantly from state to state – in operation, complexity, and severity – but they share the goal of compelling insurers to promptly and fully pay all legitimate claims.

Texas's healthcare prompt-pay statutes are among the most punitive in the nation in that they allow substantial penalties when an insurer fails to pay a claim timely, even if by only a single day. Texas law also allows recovery of attorney fees for lawsuits brought by healthcare providers to recover payment for services, which, when coupled with the punitive nature of the statutes, appears to encourage plaintiff lawyers to solicit clients to pursue prompt-pay litigation. For example, notorious lawyer Mikal Watts (currently under criminal indictment in federal court) has been very active in soliciting clients for prompt pay litigation, as have many others.[2]

This paper provides an overview of Texas's healthcare prompt-pay statutes and compares these statutes to similar statutes in other states. TLR Foundation is undertaking further research to address the questions of whether Texas's statutes are excessively punitive to accomplish the prompt payment of legitimate claims and whether Texas's statutes are encouraging unnecessary litigation.

II. A Brief History of Healthcare Prompt-Pay Laws

Nationally, the impetus behind prompt-pay laws was based in healthcare providers' unhappiness with the unpredictability and delay associated with getting paid for services provided to privately insured patients.[3] Although some insurers[4] consistently processed claims within 30 days, other insurers might take as long 120 days to pay claims. Providers alleged that these late-paying insurers unfairly profited from the "float" time between submission and payment of claims. Moreover, different insurers often had differing requirements for claim submission, and when a provider's claim was returned for failure to fully comply with that insurer's specific requirements, additional delays resulted. This unpredictability in the reimbursement process caused numerous healthcare providers to experience cash flow difficulties and other operational problems.

In seeking to remedy these reimbursement difficulties legislatively, rather than contractually, providers argued that they lacked sufficient bargaining power to negotiate satisfactory claim-processing deadlines due to the fact that most healthcare markets are dominated by only a few major insurers.[5] Providers also argued that seeking to reform insurer reimbursement practices via litigation was ineffective, as large class action suits were cumbersome and claim-by-claim litigation was cost-prohibitive.[6]

Unsatisfied with their ability to alter insurer payment practices either by contract or through litigation, physicians and hospitals turned to the legislative arena, with great success. In 1998, only 17 states had prompt-pay laws. Five years later, in 2003, that number had grown to 47 states.[7] Moreover, after initially adopting prompt-pay laws, many states have continued to amend their statutes, further tightening requirements imposed on insurers. Texas similarly expanded and strengthened its own prompt-pay laws in 2003.[8] As a result, "Texas's current prompt-pay statute is the most provider-friendly statute in the country, considering the penalties and protections offered."[9]

III. Overview of Texas's Healthcare Prompt-Pay Statutes

In Texas, the current prompt-pay statutes stem from various incremental enactments, some of which date back to the early 1990s.[10] However, the most important legislative enactments were 1999's House Bill 610, and 2003's Senate Bill 418. Although House Bill 610 (1999) established the prompt-pay framework still utilized in Texas's statutes, that framework was greatly expanded by Senate Bill 418 (2003). Today, the Texas Prompt Pay Act ("TPPA") is codified in the Texas Insurance Code as Subchapter J of Chapter 843 (governing health maintenance organizations (HMOs)) and Subchapters C and C-1 of Chapter 1301 (governing preferred provider organizations (PPOs)). And so, while this article refers to a monolithic "act," the TPPA is in fact comprised of two similar-but-separate statutes, each of which deals with a specific type of insurance plan. Additionally, the TPPA is subject to administrative rules adopted by the Texas Department of Insurance, the majority of which are found in Subchapter T, Chapter 21, Volume 28, of the Texas Administrative Code.

A. How the TPPA Works, In Brief

The TPPA establishes a set of universal "clean claim" formats. All submitted claims are required to comply with these prescribed formats, and the health insurance companies are required to accept claims submitted in the prescribed formats.[11] Next, the TPPA established a series of universal deadlines requiring insurance companies to either pay or deny a claim within a fixed time period, starting from the date the claim is submitted in the requisite "clean claim" format.[12] Last, the TPPA enforces pay-or-deny deadlines by establishing a system of graduated penalties, the size of which increases roughly according to the length of delay involved.[13]

B. Entities Subject to the TPPA

A broad range of healthcare "providers" are covered under the TPPA, including physicians, hospitals, chiropractors, registered nurses, optometrists, registered opticians, acupuncturists, pharmacists, and pharmacies.[14] The TPPA's terms extend to all providers performing services within Texas, regardless of where the billed insurer may be located.

Generally speaking, for the TPPA to apply, the provider must be an "in-network" provider who has contracted with the insurer.[15] The TPPA's payment deadlines (but not the TPPA's penalty provisions) extend to out-of-network providers only when the care was rendered under emergency circumstances or at the provider's request because the services were not reasonably available in-network.[16] Consequently, an insurer has an obligation to pay some out-of-network claims within the statutorily mandated timeframe, but the insurer's failure to comply with the statutory deadline incurs no penalty.[17]

The law applies to health maintenance organizations[18] and preferred provider organizations.[19] The TPPA does not apply to Medicare/Medicaid, worker's compensation coverage, Tricare and the Texas Children's Health Insurance Program, or to indemnity policies.[20] The TPPA does not appear to apply to employer-sponsored healthcare plans because of the preemptive

effect of the federal Employee Retirement Income Security Act ("ERISA"), or to third-party administrators for "self-funded" health insurance plans. But the applicability of the TPPA to employer-provided plans and third-party administrators has been the subject of litigation and conflicting decisions, a discussion of which is beyond the scope of this paper.[21]

C. Submitting a Claim and the "Clean Claim" Requirement

Under the TPPA, a provider has 95 days to submit a claim to the insurer.[22] This 95-day submission deadline is generally calculated from the date healthcare services are rendered.[23] However, for institutional providers such as hospitals, the submission deadline may run from the date of the patient's discharge.[24] Finally, where secondary insurers are involved, the deadline may run from the date the provider receives payment-or-denial notice from the primary insurer.[25]

A provider who fails to submit his claim within the 95-day deadline forfeits all right to payment, unless the delay was caused by a "catastrophic event that substantially interferes with the normal business operations of the physician or provider."[26] However, the claim-submission deadlines may be extended by contractual agreement between the insurer and provider.[27]

In initially submitting its claim, the provider is required to indicate what its "billed charges" are for the provider's services.[28]

If the provider wishes to take advantage of the TPPA's penalty provisions, the provider must submit a "clean claim" to the insurer.[29] A provider who fails to submit a "clean claim" is excluded from nearly all of the protections offered under TPPA, in that the TPPA's pay-or-deny deadlines do not begin to run unless and until a "clean claim" has been received by the insurer.[30]

Under the TPPA, a claim that is electronically filed constitutes a "clean claim" if it satisfies the federal standards established pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").[31] A claim submitted non-electronically must comply with the Texas-specific standards set out in the Texas Administrative Code.[32] The "clean claim" standards are voluminous, but, generally speaking, a "clean claim" is one that contains all information deemed necessary for the insurer to pay or deny that claim, while a "non-clean claim" is one requiring that additional information or documentation be submitted.[33]

If a submitted claim fails to qualify as a "clean claim," the insurer must notify the provider that the claim is not clean within the applicable pay-or-deny deadline.[34] If and when the provider receiving this notice re-files a corrected claim that satisfies the TPPA's "clean claim" requirements, the pay-or-deny deadline then begins running from the date the corrected claim is filed.[35] Where claims are submitted in bulk, the insurer is required to promptly process those claims that qualify as "clean claims," regardless of whether the entirety of the bundled claims meets the "clean claim" standard.[36]

Prior to the 2003 amendments to the TPPA, each insurer retained the ability to specify the data elements that would constitute a "clean claim" for that insurer.[37] Under the current TPPA, however, insurers are not allowed to exceed the universal "clean claim" standards governing both electronic and non-electronic claims, but may – as to electronic claims – contract to require fewer data elements.[38]

D. Requests for Additional Information

Once a provider has submitted its claim, the insurer is permitted to make a one-time-per-claim request for additional information from the provider, which must be relevant and necessary in assisting the insurer to determine whether that claim is payable.[39] To be valid, a written request for additional information must be made within 30 days of an insurer's receipt of a claim.[40]

If timely made, such requests will toll the applicable pay-or-deny deadline until the provider either supplies the requested information or states that it does not have the information.[41] Upon receiving either response to its request, the insurer must then pay or deny the claim by the later of the claim's original payment deadline or the 15th day after the insurer's receipt of the provider's response.[42] Note, however, that when the request for additional information is made to a third party, no tolling of the pay-or-deny deadline occurs.[43]

E. Pay-or-Deny Deadlines

Under the TPPA, once a provider has properly submitted a "clean claim" for reimbursement, the insurer is required – with very few exceptions – to either pay or deny that claim within the applicable statutory deadline as calculated from the date of the insurer's receipt of the claim.[44] The specific length of the time period for payment depends on two factors: (1) whether the claim is submitted electronically or non-electronically (i.e. on paper), and (2) whether the claim involves pharmacy services.

All properly billed non-pharmacy claims are subject to a pay-or-deny deadline of 30 days for electronically submitted claims, or 45 days for non-electronic submittals.[45] For pharmacy claims, the applicable electronic/non-electronic deadlines are 18 and 21 days, respectively, after "affirmative adjudication" of such claim.[46] Insurers and providers are barred from contractually agreeing to modify the statutory deadlines.[47] Today, nearly all Texas providers submit their claims electronically.

As discussed above[48], an insurer is allowed a one-time opportunity to temporarily toll the running of the TPPA deadlines by requesting additional information.[49] Once the pay-or-deny deadlines begin to run, however, the TPPA provides only two exceptions to the application of its penalties for failure to make timely payment. First, an insurer may make a later payment if the failure to pay the claim timely results from a "catastrophic event that substantially interferes with the normal business operations of the insurer."[50] Second, an insurer is not subject to a penalty if the insurer pays the claim timely, but the claim is underpaid and: (1) the provider does not inform the insurer that the claim is underpaid until more than 270 days after the provider receives payment from the insurer, and (2) the insurer pays the remaining balance within 3o days of receiving the provider's notice of underpayment.[51]

It is noteworthy that while the TPPA allows an insurer to deny a claim by the applicable deadline[52], it does not relieve the insurer of liability for a penalty related to a claim that should not have been denied.[53] In other words, an insurer that makes a good faith mistake in denying a claim is nonetheless fully liable under the TPPA's penalty scheme for failing to promptly pay the claim. Furthermore, unlike a substantial number of other states, the TPPA provides no "fraud exception" to its prompt-pay deadlines. Even when an insurer suspects a provider's otherwise "clean claim" is fraudulent, it nonetheless must decide whether to pay-or-deny that claim within the standard deadline.[54] Consequently, an insurer that denies a claim that ultimately turns out to be valid must pay a penalty under the TPPA, even if the insurer acted in good faith. An insurer that pays a claim that ultimately proves to be fraudulent must attempt to recover that payment within a 180-day period running from the provider's receipt of payment.[55] In this respect, the TPPA is akin to a strict liability system, in that it focuses on the *existence* of claim-payment delays, and not on the propriety of the actions, causes, or motivations behind the delay.

F. TPPA Penalties and "Billed Charges" v. "Contracted Rates"

As its name implies, the TPPA was intended to encourage timely payment of provider claims, by instituting a system of graduated penalties that are (loosely) keyed to the number of days elapsing between the date a claim is properly submitted and the date the insurer either pays or denies that claim.

The TPPA's penalty scheme applies exclusively to providers who have contracted to serve as "in-network providers" for insurers operating in Texas.[56] Under these contracts, providers typically agree to accept from the insurer a negotiated "contracted rate."[57] For TPPA purposes, the "contracted rate" includes any portion for which the insured patient assumes responsibility.[58] The contracted rate often is significantly lower than the provider's "billed charges," which are the charges for the provider's services stated on the claim submitted to the insurer that (at least in theory) represents the fee the provider would customarily charge for the services.[59] Roughly speaking, the terms "billed charges" and "contracted rate" reflect the difference between the provider's undiscounted, everyday price for a given procedure (like the regular retail price for a product in a retail store), and the discounted rate the provider has agreed to accept from the insurer as payment for the services provided (like the retailer's sale price for a product).

There appear to be no specific criteria for determining the amount a provider chooses to use as its "billed charges." Somewhat unhelpfully, the Texas Department of Insurance ("TDI") has stated on its website that while it does not regulate the amount a provider can charge for a particular service, any such "billed charge," if used to calculate a TPPA penalty, must not be "unreasonable."[60] The TDI regulations defining the phrase "billed charges" link the term to several Texas statutes prohibiting unreasonable, fraudulent, and 'two-tiered' billing practices, but do not specifically mandate that the charges be reasonable.[61]

If an insurer fails to take action on a claim within the applicable pay-or-deny period described above, the insurer then becomes subject to statutory penalties which are calculated in a manner unique to Texas. Under the TPPA's unique "loss-of-discount" penalty scheme, the two relevant factors are the number of days that have elapsed since the payment deadline, and the differential between the provider's contracted rate and the billed charges.[62]

An insurer who timely pays a provider's claim is liable only for the "contracted rate" (the sale price). Should the insurer fail to make payment within the statutory deadline, however, then the insurer owes both the contracted rate plus a penalty based on the difference between the contracted rate (the sale price) and the provider's undiscounted billed charge (the retail price).[63] The following paraphrased examples taken from the Texas Administrative Code demonstrate how the penalty is calculated:[64]

> As to claims paid late, but within the first 45 days after the pay-or-deny deadline has passed, the insurer may be penalized the lesser of $100,000[65] or 50% of the difference between the "billed charges" and the "contracted rate."[66]
>
> > **EXAMPLE:** If a provider's contracted rate is $10,000 and its billed charges are $15,000, and the insurer pays the provider's claim within the first 45 days after the deadline for payment passes, then the insurer is required to pay a $2,500 penalty (50% of the difference between the discounted and undiscounted rates).
>
> As to claims paid in the period from 46 to 90 days after the pay-or-deny deadline has passed, the insurer may be penalized the lesser of $200,000 or 100% of the difference between the "billed charges" and the "contracted rate."[67]

> **EXAMPLE:** If a provider's contracted rate is $10,000 and its billed charges are $15,000, and the insurer pays the claim more than 45 days but less than 90 days after the statutory payment deadline passes, then the insurer is required to pay a $5,000 penalty (100% of the difference between the discounted and undiscounted rates).

> As to claims paid in the period more than 91 days after the pay-or-deny deadline has passed, the insurer may be penalized the lesser of $200,000 or 100% of the difference between the "billed charges" and the "contracted rate"; and the amount owed as a penalty accrues 18% annual interest, from the date upon which the original payment was due.[68]

While TPPA penalties undeniably grow harsher as an insurer's delay in payment grows longer, the correlation is not a precisely calibrated one. Instead of permitting monthly or daily penalty increases, as other states do, the TPPA instead sets up three broad "zones," and within each zone all unpaid claims are treated equally. Under this system, an insurer that pays a claim 44 days after the initial pay-or-deny deadline is penalized no more harshly than an insurer that pays only one day after the deadline, as both offenses lie within a common "zone."

As is obvious from these examples, the greater the disparity between a provider's "billed charges" and "contracted rate," the larger the penalty the provider (and, in some cases, the State of Texas) stands to recover under the TPPA. Conversely, if a provider charges all of its patients a single, common rate, there would be no basis on which to calculate a penalty.[69] This statutory scheme thus creates an incentive for providers to set their billed charges at the highest defensible rate. Accordingly, concerns have been raised that, in an attempt to maximize the penalties that may be collected through the TPPA penalty system, providers may artificially inflate their "billed charges" to levels bearing no relation to their real-world market value.[70]

As to the question of who receives a penalty paid by an insurer under the TPPA, the answer depends on the type of provider involved. As to a "clean claim" submitted by a non-institutional provider (*i.e.*, a physician), the provider is entitled to any TPPA-required penalty, save for the 18% interest, which is paid to the State of Texas (in lieu of the now-abolished Texas Health Insurance Risk Pool to which the TPPA refers[71]).[72] As to a "clean claim" submitted by an institutional provider (*i.e.*, a hospital), 50% of the total penalty amount (including interest) is awarded to the provider, while the remaining 50% goes to the State.[73]

The Texas Legislative Budget Board's Fiscal Note accompanying recent proposed TPPA reform legislation[74] indicated that in 2013, the Texas General Revenue Fund took in $41 million in penalties paid under the TPPA.75 The Fiscal Note also estimated that the 2015 reform legislation – which was proposed but not enacted, and sought to substantially reduce the TPPA's maximum penalty ceilings – would cost the State of Texas $32.8 million per year, by reducing the size of the penalty recoveries in which the State of Texas shares.[76]

G. Underpayment

When an insurer makes timely partial payment, but fails to pay the entire amount owed, the TPPA penalizes these underpayments through a similar, three-zone system of penalties, with similar ceilings and interest awards.[77] Underpayment penalties are primarily calculated on the amount left unpaid, rather than directly on the difference between the billed charges and the contracted rate. Nonetheless, within the complex formula that is used to calculate the underpaid amount[78], the billed charges and contracted rates indirectly affect the penalty owed by the insurer in the underpayment context.[79]

The Texas Department of Insurance supplies the following illustration of the TPPA's application in an underpayment scenario:

> **EXAMPLE:** [A] claim for a contracted rate of $1,000 and billed charges of $1,500 is initially underpaid at $600, with the insured owing $200 and the HMO or preferred carrier owing a balance of $200. The HMO or preferred provider carrier pays the $200 balance on the 30th day after the end of the applicable statutory claims payment period. The amount the HMO or preferred provider carrier initially underpaid, $200, is 20 percent of the contracted rate. To determine the penalty, the HMO or preferred provider carrier must calculate 20 percent of the billed charges minus the contracted rate, which is $100. This amount represents the underpaid amount for subsection (c)(1) of this section. Therefore, the HMO or preferred provider carrier must pay, as a penalty, 50 percent of $100, or $50.[80]

H. Audit Requirements

Prior to the TPPA's enactment, Texas providers frequently complained of payment delays connected to an insurer's decision to audit the provider's claim.[81] Today, should an insurer desire to audit a particular claim but be unable to complete that audit within the TPPA pay-or-deny deadlines, the insurer must timely pay the claim in full, pending the outcome of the audit.[82] No audit-related deadline extensions are available under the TPPA, and conducting a good faith audit does not exempt the insurer from paying a penalty if the claim being audited is paid after the pay-or-deny deadline passes.[83] Should an insurer choose to pay only the undisputed portion of a claim that is being audited, the insurer's action triggers the underpayment penalties discussed above as to the disputed portion left unpaid.[84]

If payment is being made subject to an ongoing audit, the insurer must notify the provider of that fact, and then complete the audit within 180 days of receiving a "clean claim."[85] If the completed audit reveals that payment was improper, the insurer may request a refund within 180 days of the provider's receipt of the overpayment, or 30 days after notifying the provider of the audit's completion.[86]

I. Recoupment Deadlines

Under Texas law, once an insurer has paid a provider's claim, if it thereafter discovers that an overpayment has been made, that insurer has 180 days from the provider's receipt of such payment to provide written notice that recovery is sought.[87] When an insurer seeks recoupment, the provider must be given an opportunity to appeal and the insurer cannot recover its refund until all appeal rights have been exhausted.[88] However, the recoupment deadlines and restrictions do not apply if the provider is guilty of either fraud or material misrepresentation.[89]

J. Attorney Fees

The TPPA expressly provides that a "provider may recover reasonable attorney's fees and court costs in an action to recover payment."[90] An insurer is barred from altering this right-of-recovery by contract.[91]

K. Administrative Penalties

In addition to individualized penalties that may be paid to a provider or the State of Texas under the TPPA, the TPPA also permits assessment of separate administrative penalties (assessed by the Texas Department of Insurance) against an insurer whose overall rate of compliance with TPPA's pay-or-deny deadlines for "clean claims" falls below 98%.[92] Compliance is

determined by quarterly reports submitted by the insurers, in which claims are categorized as either institutional or non-institutional.[93] Should an insurer fail to meet this 98% compliance threshold, the maximum per-day penalty may not exceed $1,000 for each claim remaining unpaid in violation of the TPPA.[94]

L. Anti-Retaliation Protections

The TPPA provides that insurers are barred from engaging in any retaliatory action – such as cancellation, refusal to renew, or termination – against a provider who has filed a complaint against an insurer or appealed an insurer's reimbursement decision.[95] These retaliation protections are required to be inserted into all contracts between insurers and providers, along with the TPPA's prompt-payment protections.[96]

M. Verification and Pre-Authorization

Prior to actually performing a given procedure, providers may contact the patient's insurer to obtain verification that the insurer will pay for the proposed healthcare services.[97] Under the TPPA, if a provider supplies all required information regarding the proposed procedure, the insurer is required to respond to the verification request "without delay" and inform the provider whether the service will be covered, and specify any amounts for which the patient is responsible.[98] Insurers are required to make a good faith effort to address all provider requests for verification, and may decline a given request only by offering reasons specific to that request.[99]

Once the insurer has verified that it will pay for the healthcare services, the insurer cannot deny or reduce payment, unless the provider either materially misrepresented the services provided or substantially failed to provide the services.[100] An insurer may decline to provide verification if, at the time of the provider's request, the insurer cannot adequately determine its liability and the insurer notifies the provider of the specific reason it cannot adequately determine its liability.[101]

The TPPA also governs situations where insurers choose to require providers to obtain "pre-authorization" for medical procedures.[102] Whereas verification essentially involves two representations (that the proposed procedure is medically necessary and appropriate, and that the insurer will pay for the procedure), pre-authorization determinations are limited to medical necessity only.[103] Thus, if an insurer chooses to pre-authorize a proposed procedure, the insurer is thereafter barred from denying or reducing coverage based on medical necessity or appropriateness of care, absent fraud on the part of the provider.[104]

N. Statutes of Limitations

The specific time limitations governing a provider's ability to recover penalties under the TPPA depends on whether the insurer entirely fails to reimburse a submitted claim or, instead, pays only a portion of that claim.

The TPPA's protections extend to any underpaid provider who notifies the insurer within 270 days of receiving the underpayment.[105] If the underpaid provider informs the insurer of the underpayment after this 270-day deadline has passed, and if the insurer pays the claim within 30 days of receiving the belated complaint, then no TPPA penalties apply and the insurer is liable only upon the underpaid amount.[106] The provider's ability to recover on the underpaid amount (apart from any TPPA-authorized penalties) is subject to the four-year limitation governing an action for breach of contract.[107]

Somewhat anomalously, as to claims the insurer entirely fails to pay, the provider appears to have the entire four year limitation period applicable to a debt in which to bring its action against the insurer, including for recovery of both the unpaid claim and any applicable TPPA penalties.

IV. Comparison of Texas's Statutes to Other States' Statutes

A. "Clean Claim" Requirement

The penalty provisions of the TPPA are triggered in Texas and many other states by the provider's submission of a statutorily defined "clean claim." Nineteen of 51 United States jurisdictions, however, have chosen to enact prompt-pay statutes that apply to more claims that just "clean claims."[108] In this regard, the TPPA's scope is somewhat less expansive than the scope of similar statutes in 19 states. For the purposes of productively comparing Texas's statutes to those of other jurisdictions, this article focuses on the treatment of "clean claims" in Texas and other states.

B. Payment Deadlines

In Texas, the pay-or-deny deadline for electronic claims (excluding pharmacy claims) is 30 days.[109] Thirty-one other jurisdictions also have a 30-day pay-or-deny deadline.[110] Nine jurisdictions have chosen shorter deadlines of 15, 20, 21, and 25 days, respectively.[111] The remaining ten American jurisdictions have chosen longer deadlines, of which 45 days is the most popular.[112] The nation's longest pay-or-deny deadline is in Arizona, which has an effective 60-day time limit that provides insurers 30 days in which to approve a claim and an additional 30 days in which to pay it.[113]

Thus, in respect to pay-or-deny deadlines, the TPPA's 30-day limit (for clean, electronic, non-pharmacy claims) falls within the American mainstream.

C. Exceptions To Payment Deadlines

The TPPA severely limits an insurer's ability to evade compliance with the TPPA's pay-or-deny deadlines, creating a standard akin to strict liability.[114] More specifically, once a "clean claim" has been submitted, a Texas insurer's actions are limited to: (i) paying the claim in full, and seeking recoupment if the claim was over-paid or not owed, (ii) sending a one-time request for additional information, which temporarily postpones the pay-or-deny deadline, (iii) sending partial payment with a notice explaining why part of the claim will not be paid, which will trigger a TPPA penalty if the unpaid portion of the claim is owed, (iv) failing to meet the pay-or-deny deadline because of the occurrence of a "catastrophic event," which temporarily excuses compliance with the TPPA deadline, and (v) failing to timely pay the claim altogether, which triggers TPPA penalties.[115] An insurer's good faith belief that the claim is not owed or is fraudulent does not allow the insurer to fail to comply with the TPPA's pay-or-deny deadline, nor to escape TPPA penalties.

Other jurisdictions are more lenient than Texas and recognize additional exceptions to an insurer's duty to meet that state's prompt-payment deadline. Over half of American jurisdictions, for example, recognize some form of "fraud exception," either by explicitly providing that the insurer is not required to pay promptly if there is evidence of fraud or misrepresentation, or by excluding potentially fraudulent claims from the statutory definition of "clean claim."[116]

D. Recoupment Deadlines

Under Texas law, once an insurer has paid a provider's claim, if the insurer thereafter discovers that an error has been made, the insurer has 180 days from the provider's receipt of payment to provide written notice that recovery is sought.[117] Among the other 50 jurisdictions, only the District of Columbia, Maryland, and Nebraska employ such short recoupment deadlines.[118] New Hampshire allows an eight month recoupment window, and ten other jurisdictions set the limit at one year.[119] The remaining 36 jurisdictions have established significantly longer recoupment periods, or set no time limits at all.[120]

Moreover, while Texas does not recognize a fraud exception to its recoupment deadline, more than 20 jurisdictions expressly do. Another 20 states apply no deadlines to any recoupment claim, whether fraud-based or otherwise.[121]

E. Provider-Awarded Monetary Sanctions

Texas is truly an outlier amongst the nation's prompt-pay statutes in the size and range of penalties applicable to insurers that violate the TPPA's provisions. In Texas, a failure to promptly pay or deny provider claims can result in three different types of monetary sanctions: "loss-of-discount" penalties, interest on those penalties, and administrative penalties.[122] Arguably, only Missouri rivals Texas in the magnitude of the penalties that may be imposed on its insurers[123]; but Texas is completely unmatched in the speed with which substantial penalties accumulate.

In a slight majority of American jurisdictions – 27 of 51 – if an insurer fails to promptly pay a submitted claim, the only penalty is that interest accrues on the unpaid claim.[124] A significant number of jurisdictions allow the state itself to impose (and to keep) administrative penalties, but only a handful of jurisdictions augment the provider's recovery beyond an award of interest on the unpaid claim.[125] Because of these differences, most of the prompt-payments statutes in other states are far shorter, and far simpler, than the TPPA. In Wyoming, for example, the applicable prompt-pay statute consists of three short paragraphs.[126]

1. Interest as the Provider-Awarded Penalty

Under the majority of American prompt-payment statutes, the sole penalty mechanism is the accrual of interest on the unpaid claim, most often at an effective annual rate of between 10% and 18%.[127] Texas is different. While interest is recoverable under the TPPA, Texas law is unique in that: (1) interest does not become available until after "loss-of-discount" penalties have been imposed, and (2) interest accrues on the penalties themselves, and not on the provider's unpaid claim. Additionally, Texas is distinct in that some TPPA-mandated interest is paid to the State of Texas (in lieu of payment to the now-abolished Texas Health Insurance Risk Pool to which the TPPA refers), rather than to the late-paid provider.[128]

Because of the factors discussed above, the interest penalties imposed under Texas law are distinct from those available in other states. Nonetheless, for the sake of rate-comparison, interest accrues at 18% annually when available under the TPPA. Approximately ten other states also set the applicable interest rate at 18%, which is high in today's interest-rate environment. Only a handful of jurisdictions – including the District of Columbia, Kentucky, and Maryland – have established progressive-rate mechanisms, whereby the applicable interest rate can eventually exceed 18%, by allowing that rate to escalate alongside the number of days a claim remains unpaid.[129] In the District of Columbia and Maryland, for example, claims remaining unpaid for more than 120 days accrue interest at 2.5% per month, for an effective annual rate of 30%.[130]

Other states also have aggressive interest-based penalties. In Utah, for example, for the first 90 days after a claim deadline passes, the insurer is assessed a per-day penalty equivalent to .1% of the unpaid claim. When more than 90 days have elapsed, however, the insurer becomes liable for both the .1% late fee (now at 9% of the claim), plus a second penalty achieved by multiplying: (i) the total amount of the unpaid claim, (ii) the numbers days unpaid beyond 90 days, and (iii) the applicable statutory interest rate.[131] In Missouri, unpaid claims are penalized both by the accrual of interest (at 1% per month), plus an additional penalty of 1% per day.[132] By way of contrast, Indiana's effective annual rate of interest has floated as low as 2%.[133]

Furthermore, a number of states' prompt-pay interest rates are pegged to statutory formulas, rather than to a statutorily fixed interest rate.[134] Consequently, it is possible that during high interest rate periods, these formulas may generate rates above Texas's 18%.

2. Non-interest Provider-Awarded Penalties

Under the vast majority of prompt-pay statutes, the provider's recovery is limited to an award of interest upon the unpaid claim, as discussed above. Only a handful of jurisdictions have joined Texas in allowing the provider – as opposed to the state – to receive any amount in addition to interest on the claim. None are as punitive as Texas. In Colorado, for example, if a claim remains unpaid past 90 days, a one-time penalty of 20% of the claim's total amount is assessed.[135] In Colorado, the accrual of interest is the first-tier penalty, and an additional penalty is added later if the claim remains unpaid past 90 days. Texas is the opposite.

In Texas, the first layer of penalties imposed on an insurer is a "loss-of-discount" penalty. As noted above, if an insurer has failed to pay a $10,000 claim within 30 days after the provider submitted the claim (*i.e.*, failed to pay the amount owed within the pay-or-deny deadline), and the provider's undiscounted "billed charges" are $15,000, then on the 31st day after submission of the claim, the insurer owes $12,500 (the $10,000 contracted rate plus 50% of the $5,000 differential between the contracted rate and the billed charges). If the billed charges are $25,000 rather than $15,000, then on the 31st day after submission of the claim, the insurer owes $17,500 (the $10,000 contracted rate plus 50% of the $15,000 differential between the two figures).

The penalty is doubled if the insurer pays the claim more than 75 days after it is submitted. If, on the 76th day after submission (46 days after the pay-or-deny deadline passes), the insurer has not paid a $10,000 claim, then the total amount owed is $15,000 (the $10,000 contracted rate plus 100% of the $5,000 differential between the contracted rate and the billed charges). If the billed charges are $25,000 rather than $15,000, then on the 76th day after submission of the claim, the insurer owes $25,000 (the $10,000 contracted rate plus 100% of the $15,000 differential between the two figures). In the second example, the penalty is more than double the amount of the claim, in only 76 days.

In Texas, unlike any other state, the severity of the penalty depends on the magnitude of the difference between the submitting provider's billed charges and the provider's contracted rate. The greater the difference between the contracted rate and the billed charges, the greater the penalty paid by the insurer. Even a relatively mild difference between the two figures will result in a penalty that is far higher than the most onerous penalty available in any other state.

Furthermore, as noted above, the billed charges are set by providers in their discretion, without any firm statutory limits. Consequently, under Texas law, the amount of penalty an insurer will pay is established not by statute as in other states, but, instead, is within the control of the person who provided services and receives the penalty.

Additionally, the Texas loss-of-discount penalty calculus is frontloaded. Under Texas law, *on the very first day* after the applicable pay-or-deny deadline has passed, the insurer is inescapably obligated to pay what often is a sizeable loss-of-discount penalty. That loss-of-discount penalty then doubles 45 days later. In contrast, 18% interest on a claim – which is a common penalty rate in other states – would in many cases require years to equal the penalty imposed in Texas on a claim that is only one day overdue. Missouri's 1%-per-day penalties would eventually outstrip those available under the TPPA; but in most cases, because of the large difference between contracted rates and billed charges that prevail in Texas, it would likely take a long time for the 1% per day Missouri rate to be more punitive than the penalties imposed in Texas.[136]

F. State Administrative Penalties

Nationwide, administrative prompt-pay penalties roughly break down into two categories: claim-specific or global-compliance. A significant minority of states (not including Texas) allow the imposition of state-collected administrative fines based upon an insurer's handling of specific claims (as opposed to the insurer's cumulative track record in handling of *all* claims within a given time period). States permitting the imposition of these claim-specific fines include Alabama, Arizona, Idaho, Louisiana, Michigan, Missouri, Nebraska, New Mexico, and North Carolina.[137] Moreover, several of these states – including Louisiana, Nebraska, and New Mexico – expressly provide for significantly increased penalties when the violation is determined to have been intentional or flagrant.[138]

The second category of administrative penalties is the global-compliance variety, as are featured under the TPPA.[139] As discussed above, the Texas Department of Insurance is permitted to impose administrative penalties when an insurer's overall claims-processing performance falls below statutorily established standards (*i.e.*, on-time processing of 98% of the claims submitted in a given quarter). Once the global threshold has been breached, the per-day amount of the resulting administrative penalty is calculated based on the specific number of untimely claims.[140]

A handful of other jurisdictions likewise impose global-compliance targets – including Indiana, Kentucky, Mississippi, Montana, Tennessee and Washington[141] – but no other state has fixed their compliance target higher than 95%.[142] Notably, a 95% compliance rate is equivalent to the prompt-pay standard that the federal government has imposed on itself in handling Medicare claims.[143]

Rather than utilizing fixed compliance percentages, numerous other states' prompt-pay laws have provisions granting the enforcing entity more generalized powers to impose administrative penalties when a given insurer is determined to have engaged in an overall pattern of noncompliance. These states include New Hampshire, New Jersey, New York, and Ohio.[144]

Finally, Idaho utilizes a hybrid approach, in which it retains discretion to impose administrative penalties for specific acts of noncompliance unless the insurer can show a 95% global-compliance rate in its handling of all claims.[145]

G. Attorney Fees

The TTPA explicitly provides for recovery of attorney fees. Among the 51 American jurisdictions, only nine states expressly allow recovery of attorney fees in litigation brought under their prompt-payment-of-claims statutes (Maine, Missouri, Nevada, New Hampshire, Oklahoma, Texas, Virginia, West Virginia, and Wyoming), and New Hampshire limits recovery of attorney fees to those instances when the insurer has acted in bad faith.[146]

Conceivably, a provider suing on an unpaid healthcare claim might have other avenues to recover its attorney fees – such as by establishing breach of contract, or fraud – but Texas is one of the few jurisdictions that expressly provides for recovery of attorneys fees by all providers who recover payments owed under the TPPA.[147]

H. Explicit Ability to Bring a Private Action

An incidental effect of the TPPA's attorney fees provision (as well as those of the other states discussed above) is that it necessarily grants providers a clear right to bring suit against insurers for prompt-pay violations. According to some commentators, only a minority of states provide clear-cut statutory permission for providers to bring suit for prompt-pay violations.[148] Elsewhere, the right to sue might be found to exist by the courts, but is not explicitly provided in the prompt-pay statute.

In contrast, both Montana and Idaho forbid any private cause of action based on the failure to comply with their prompt-pay deadlines; and Hawaii explicitly grants its Commissioner of Insurance the sole right to pursue remedies and penalties under its prompt-pay act.[149]

Finally, North Dakota and South Dakota have enacted healthcare prompt-pay statutes that appear to lack any enforcement mechanism.[150] Nebraska and South Carolina previously employed a similar "honor system" approach, but have recently incorporated penalty provisions.

I. Texas's Uniqueness

As described in the previous sections, Texas's prompt-pay statutes are unique in some respects, and outside the mainstream in other respects.

- Texas is one of a handful of states with a graduated penalty structure, whereas other states typically allow steadily accruing interest on the unpaid claim.
- Texas is unique in that, although it utilizes a graduated penalty structure, that structure does not precisely "track" the payment delay, but instead employs three "zones." Thus, under the TPPA, an insurer that pays-in-full one day after the pay-or-deny deadline is treated no more favorably than an insurer that pays 44 days late.
- Texas's "front-loaded" penalty system is unique in that no other state allows potentially large penalties in such a short time. Depending on the differential between the "contracted rate" and the "billed charges" claimed by the provider (which can be substantial), Texas is unmatched in the magnitude of penalties that can be generated by a delay of just one day past the pay-or-deny deadline.
- In calculating the amount of provider-awarded penalties, Texas is alone in basing that penalty on the differential between the provider's discounted and non-discounted rates, the latter of which is not required to have any firm, "real-world" basis. On the other hand, were a provider to charge his insured and non-insured patients a common rate, the TPPA is unique in denying that provider any protection whatsoever.
- Texas also appears to be one of the few jurisdictions in which the state is entitled to a meaningful part of the non-administrative penalties imposed on insurers. In 2013, TPPA payments to the State of Texas exceeded $41 million.
- Texas is unique in that the interest aspect of a TPPA penalty accrues on the already levied TPPA penalties, and not on the underlying unpaid claim itself.
- Texas imposes the nation's highest global-compliance rate – 98% – for the timely processing of claims, which it enforces via separate administrative penalties.
- Texas belongs to the minority of states that explicitly permit providers to recover attorneys fees incurred in bringing successful prompt-pay actions.

The most unusual feature of the TPPA is its unique loss-of-discount penalty structure, premised on the differential between the "contracted rate" and the provider's self-reported "billed charges." In nearly all other states, prompt-payment penalties are interest-based and calculated by multiplying the amount of the unpaid claim by the period of delay. In Texas, however, loss-of-discount penalties are calculated in a far more complicated manner, with less predictable results.

By way of illustration, let us assume that Texas physicians X, Y, and Z all agree with Insurer to accept $10,000 for a given procedure, yet the respective claims submitted by them list widely differing "billed charges" reflecting each physician's undiscounted rate. Physician X,

for example, lists his billed charges as $10,000, Physician Y lists hers as $15,000, and Physician Z sets his billed charges at $20,000. Should Insurer fail to pay all three Physicians until the 46th day after the applicable pay-or-deny deadline, Physician Z would essentially double his money, with a $10,000 penalty. Physician Y would receive $5,000, and Physician X would receive $0, despite the fact that all three providers experienced identical delays while awaiting payment of identically sized claims. As demonstrated by the comparative outcomes for Physicians X and Z, the TPPA's gives providers an incentive to set their "billed charges" as high as possible, all else being equal.

The disparity of outcomes between similarly situated providers appears to lack any rational basis. Providers have argued that the TPPA's front-loaded, rapidly accruing penalty structure provides a "hammer" to compel insurers to speedily process claims and settle disputes.[151] The statutes of all other states, on the other hand, appear to reflect the belief that the prompt payment of healthcare claims can be achieved by calculating penalties based on an "unpaid amount times days late" formula, especially when the formula is supported by a sufficient penalty interest rate.

V. Conclusion

The healthcare prompt-pay laws currently in force in Texas are unique in many respects, most particularly in that the TPPA's penalty scheme is rooted in a "loss-of-discount" model, under which the amount of a penalty is governed by the provider's "billed charges." This model can produce anomalous results between similarly situated providers, and, all else being equal, makes it advantageous for providers' billed charges to be as high as possible. Moreover, the TPPA's penalty scheme is uniquely front-loaded in a manner not replicated in any other jurisdiction. This front-loaded scheme can generate significant penalties for payments by insurers that are only a single day late. Furthermore, the TPPA has elements that are akin to strict liability, provides a private right of action, and provides for a mandatory award of attorney fees to a lawyer representing a provider that is successful in litigation brought under the TPPA. Cumulatively, these TPPA provisions appear to be encouraging data-mining, client solicitation efforts, and litigation brought by enterprising attorneys.

Although the prompt-pay statutes in other states are not uniform, most other states rely on an interest-only model that closely correlates the penalty to the tardiness of the insurer's payment. These provider-paid penalties often are coupled with administrative penalties, paid to the state, that are imposed when an insurer fails to pay 95% of its healthcare claims on time.

No matter the scheme, the central impetus behind all prompt-pay statutes is to ensure quick and full payment of providers' legitimate claims. Achieving the goal of prompt and full payment of providers' claims – without causing excessive administrative activity or inviting excessive litigation – should remain the metric by which to analyze the TPPA. ■

ENDNOTES

1 Michael Flynn, *The Check Isn't In The Mail*, 10 DEPAUL J. HEALTH CARE L. 397, 403 (2007).

2 *See, e.g., Mikal Watts Speaks Out on Legal Battle with Insurance Companies for Prompt Pay*, (Feb. 13, 2013), available at http://finance.yahoo.com/news/mikal-watts-speaks-legal-battle-140800176.html (reporting that Watts' law firm "recently formed the 'Prompt Pay Claims Resolution Group' and invested millions of dollars in medical data mining software to identify unpaid and underpaid health insurance claims").

3 Hygeia, *Managed Care Compliance Series, Part Two: U.S. Prompt Pay Regulations on Medical Claim Payment – Executive Summary* (2005), available at https://hygeia.net/whitepapers/whitepapers/2005_03_US_Prompt_Pay_Regulations_on_Medica_Claim_Payment_-_Executive_Summary.pdf.

4 "Insurer" is the term used consistently in the prompt payment of claims statute applicable to PPOs. *See, e.g.*, TEX. INS. CODE § 1301.102(a) ("A physician or health care provider must submit a claim to an insurer..."). The statute applicable to HMOs typically uses the term "health maintenance organization," although it also sometimes uses "insurer." *See, e.g.*, TEX. INS. CODE § 843.337(a) ("A physician or health care provider must submit a claim to a health maintenance organization...").
In this paper, "insurer" is used as a generic term to refer to the party that is required to pay healthcare provider claims.

5 Dave Hansen, *The Failed Promise of Prompt Pay*, (Nov. 5, 2007), available at http://www.amednews.com/article/20071105/government/311059978/4/.

6 James W. Marks, *Prompt Pay Statutes for Physicians' Billing Claims: An Imperfect Remedy for a Systemic Problem*, 20 J. MED. PRAC. MGMT. 135 (2004).

7 Errol J. King, *Prompt-Pay Insurance Laws a Continuing "Hotbed Of Activity"*, FED'N REG. COUNS. J., Vol. 16, Ed. 3, n. 1 (Fall 2005).

8 *See* Act of June 1, 2003, S.B. 418, 78th Leg., R.S., ch. 214, 2003 Tex. Gen. Laws 1016.

9 Russell G. Thornton, Michael A. Yanof, *Getting Stiffed No Longer Needs To Be A Cost of Doing Business: Texas Prompt Pay Provisions*, 22 PROC. BAYLOR U. MED. CENTER (2009) at 83.

10 *See* Texas Senate Special Committee on Prompt Payment of Health Care Providers, Interim Report to the 78th Legislature, November 2002, at 1.5-1.8, available at http://www.senate.state.tx.us/75r/Senate/commit/c950/c950_77.htm.

11 *See* Section III.C., *infra*.

12 *See* Section III.E., *infra.*

13 See Section III.F., *infra*.

14 TEX. INS. CODE §§ 843.002(22), (24), 1301.001(1-a), (6). While the TPPA refers to both "physicians and providers," this article refers to all of these parties as "providers."

15 TEX. INS. CODE §§ 843.344, 1301.109.

16 TEX. INS. CODE §§ 843.351, 1301.069.

17 *See* "Payment – Penalty Payments" section of TDI Prompt Pay FAQs, at http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment.

18 TEX. INS. CODE Ch. 843 (chapter entitled "Heath Maintenance Organizations"); TEX. INS. CODE § 843.338 (creating pay-or-deny deadline for claims submitted to health maintenance organization by a participating provider); TEX. INS. CODE § 843.342(a) (requiring health maintenance organization to pay penalty to a provider).

19 TEX. INS. CODE Ch. 1301 (chapter entitled "Preferred Provider Benefit Plans");
TEX. INS. CODE § 1301.103 (creating pay-or-deny deadline for claims submitted to insurer by preferred provider);
TEX. INS. CODE § 1301.137(a) (requiring insurer to pay penalty to a preferred provider).

20 *See* "General Prompt Pay Questions – Prompt Pay and Potential Fraud" section of TDI Prompt Pay FAQs, at http://www.tdi.texas.gov/hprovider/ppsb418faq.html#general.

21 *See, e.g., Aetna Life Ins. Co. v. Methodist Hosp. of Dallas*, 95 F. Supp. 3d 950 (N.D. Tex. 2015) (Third-party administrator of self-funded health insurance plans brought action against healthcare providers seeking declaratory judgment that TPPA does not apply to self-funded plans, or, if it does, then it is preempted by ERISA); *Health Care Serv. Corp. v. Methodist Hosp. of Dallas*, Case No. 3:13-CV-4946-B (N.D. Tex., Jan. 28, 2015) (same).

22 TEX. INS. CODE §§ 843.337(a), 1301.102(a).

23 TEX. INS. CODE §§ 843.337(a), 1301.102(a).

24 28 TEX. ADMIN. CODE § 21.2806(a) (Tex. Dep't of Ins., Claims Filing Deadline).

25 *Id.*

26 TEX. INS. CODE §§ 843.337(b), 1301.102(d).

27 TEX. INS. CODE §§ 843.337(c), 1301.102(e).

28 28 TEX. ADMIN. CODE § 21.2803(b)(1)(BB) (Tex. Dep't of Ins., Elements of a Clean Claim);
see also TEX. INS. CODE § 843.342(a)(1), (b)(1) (imposing penalty based on "the difference between the billed charges, *as submitted on the claim*, and the contracted rate") (emphasis added); TEX. INS. CODE § 1301.137(a)(1), (b)(1) (same); Section III.F., *infra* (discussing "billed charges").

29 28 TEX. ADMIN. CODE § 21.2807 (Tex. Dep't of Ins., Effect of Filing a Clean Claim).

30 TEX. INS. CODE §§ 843.337(b), 843.338, 1301.102(d), 1301.103.

31 28 TEX. ADMIN. CODE § 21.2802(6)(B) (Tex. Dep't of Ins., Definitions); 28 TEX. ADMIN. CODE § 21.2803(e), (f) (Tex. Dep't of Ins., Elements of a Clean Claim).

32 See 28 TEX. ADMIN. CODE § 21.2803(b) (Tex. Dep't of Ins., Elements of a Clean Claim).

33 TEX. INS. CODE §§ 843.336, 1301.131; 28 TEX. ADMIN. CODE § 21.2803(b) (Tex. Dep't of Ins., Elements of a Clean Claim).

34 TEX. INS. CODE §§ 843.338(3), 1301.103(3).

35 28 TEX. ADMIN. CODE § 21.2807(a) (Tex. Dep't of Ins., Effect of Filing a Clean Claim).

36 TEX. INS. CODE §§ 843.323, 1301.0641.

37 *See* TEX. INS. CODE Article 3.70-3C, § 3A(j) (uncodified) *and* TEX. INS. CODE § 843.341(b), (c) (codified), *both repealed by* Act of June 1, 2003, S.B. 418, 78th Leg., R.S., ch. 214, §§ 2, 13, 2003 Tex. Gen. Laws 1016, 1019, 1028.

38 TEX. INS. CODE §§ 843.336(f), 1301.131(e), (g).

39 TEX. INS. CODE §§ 843.3385(a), (d), 1301.1054(a), (c).

40 TEX. INS. CODE §§ 843.3385 (a), 1301.1054(a).

41 TEX. INS. CODE §§ 843.338, 843.3385(a), (c), 1301.103, 1301.1054(a), (b).

42 TEX. INS. CODE §§ 843.3385 (c), 1301.1054(b).

43 TEX. INS. CODE §§ 843.3385(e), 1301.1054(d).

44 TEX. INS. CODE §§ 843.338, 1301.103.

45 TEX. INS. CODE §§ 843.338, 1301.103.

46 TEX. INS. CODE §§ 843.339, 1301.104.

47 TEX. INS. CODE §§ 843.353, 1301.107.

48 See Section III.D., *infra.*

49 TEX. INS. CODE §§ 843.3385, 1301.1054.

50 TEX. INS. CODE §§ 843.342(h)(1), 1301.137(h)(1).

51 TEX. INS. CODE §§ 843.342(h)(2), 1301.137(h)(2).

52 See TEX. INS. CODE §§ 843.338, 1301.103.

53 See TEX. INS. CODE §§ 843.342(h), 1301.137(h).

54 TEX. INS. CODE §§ 843.3405, 1301.1053.

55 TEX. INS. CODE §§ 843.350, 1301.132.

56 TEX. INS. CODE §§ 843.344, 1301.109.

57 28 TEX. ADMIN. CODE § 21.2802(8) (Tex. Dep't of Ins., Definitions).

58 28 TEX. ADMIN. CODE § 21.2815(d) (Tex. Dep't of Ins., Failure to Meet the Statutory Claims Payment Period).

59 28 TEX. ADMIN. CODE § 21.2802(3) (Tex. Dep't of Ins., Definitions).

60 *See* "Payment – Billed Charges" section of TDI Prompt Pay FAQs, at http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment.

61 28 TEX. ADMIN. CODE § 21.2802(3) (Tex. Dep't of Ins., Definitions), *citing* TEX. HEALTH & SAFETY CODE § 311.0025, TEX. OCC. CODE § 105.002, and TEX. INS. CODE Ch. 552.

62 TEX. INS. CODE §§ 843.342, 1301.137.

63 TEX. INS. CODE §§ 843.342(a), (b), 1301.137(a), (b).

64 *See* 28 TEX. ADMIN. CODE § 21.2815 (Tex. Dep't of Ins., Failure to Meet the Statutory Claims Payment Period).

65 The penalty ceilings (*i.e.* $100,000 or $200,000) are calculated per claim, and not per patient, per insurer, or per provider.

66 TEX. INS. CODE §§ 843.342(a), 1301.137(a).

67 TEX. INS. CODE §§ 843.342(b), 1301.137(b).

68 TEX. INS. CODE §§ 843.342(c), 1301.137(c).

69 In the Frequently Asked Questions section of its website, the Texas Department of Insurance explains that "[i]f there's no difference between the contracted rate and your billed charges, there's no difference upon which to compute a penalty." *See* "Payment – Penalty Payments" section of TDI Prompt Pay FAQs, at http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment.

70 *See* Texas Senate Special Committee on Prompt Payment of Health Care Providers, Interim Report to the 78th Legislature, November 2002, at 1.20, available at http://www.senate.state.tx.us/75r/Senate/commit/c950/c950_77.htm ("[Carriers] argue that penalties based on billed charges may bear little or no relation to the amount otherwise owed contractually…"); "Payment – Billed Charges" section of TDI Prompt Pay FAQs, at http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment (answering "What is considered an unreasonable billed charge?").

71 *See* TEX. INS. CODE Ch. 1506, *repealed by* Act of May 26, 2013, S.B. 1367, 83rd Leg., R.S., ch. 615, § 8, 2013 Tex. Gen. Laws 1640, 1642. The Texas Health Insurance Pool was created by the Texas Legislature to provide health insurance to eligible Texas residents who, due to medical conditions, were unable to obtain coverage from individual commercial insurers. Because the federal Affordable Care Act ("ACA") provides that insurers cannot deny coverage to a person because of a preexisting condition and requires all Americans who are not covered by a government-sponsored program to purchase private health insurance, the need for the Pool arguably disappeared after the ACA became effective. The Texas Legislature, therefore, abolished the Pool during its 2013 legislative session, and provided that the Pool's assets would be transferred to the Texas Department of Insurance. *See id.* § 6. The Legislature, however, did not cut-off the payment of prompt-pay penalties by insurers to the Pool. *See id.* Consequently, the State of Texas, in lieu of the Pool, continues to receive prompt-pay penalties from health insurers operating in Texas.

72 TEX. INS. CODE §§ 843.342(m), 1301.137(*l*).

73 TEX. INS. CODE §§ 843.342(m), 1301.137(*l*).

74 *See* Tex. H.B. 1433, 84th Leg., R.S. (2015), available at http://www.legis.state.tx.us/BillLookup/Text.aspx?LegSess=84R&Bill=HB1433.

75 *See* Texas Legislative Budget Board Fiscal Note for H.B. 1433, Mar. 17, 2015, available at http://www.legis.state.tx.us/BillLookup/Text.aspx?LegSess=84R&Bill=HB1433.

76 *Id.*

77 TEX. INS. CODE §§ 843.342(d), (e), 1301.137(d), (e).

78 *See, e.g.*, TEX. INS. CODE § 843.342(g) ("the underpaid amount is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate").

79 28 TEX. ADMIN. CODE § 21.2815(d) (Tex. Dep't of Ins., Failure to Meet the Statutory Claims Payment Period).

80 *Id.*

81 Texas Senate Special Committee on Prompt Payment of Health Care Providers, Interim Report to the 78th Legislature, November 2002, at 1.12, available at http://www.senate.state.tx.us/75r/Senate/commit/c950/c950_77.htm.

82 TEX. INS. CODE §§ 843.3405, 1301.1053.

83 *See* TEX. INS. CODE §§ 843.342(h)(1), 1301.137(h)(1) (penalty not imposed only if claim paid late because of a catastrophic event or an underpayment was not noticed until after passage of 270 days).

84 See Section III.G., *supra.*

85 TEX. INS. CODE §§ 843.340, 1301.105, 1301.1051.

86 28 TEX. ADMIN. CODE § 21.2818 (Tex. Dep't of Ins., Overpayment of Claims).

87 TEX. INS. CODE §§ 843.350, 1301.132.

88 TEX. INS. CODE §§ 843.350(b), 1301.132(b); 28 TEX. ADMIN. CODE § 21.2818(c) (Tex. Dep't of Ins., Overpayment of Claims). Although the statues and rules reference a right for a provider to appeal an insurer's decision, the right to appeal is a right for the provider to ask the insurer to review its decision, not a right to appeal in court or an appeal to appeal to an administrative agency.

89 28 TEX. ADMIN. CODE § 21.2818(f) (Tex. Dep't of Ins., Overpayment of Claims).

90 TEX. INS. CODE §§ 843.343, 1301.108.

91 28 TEX. ADMIN. CODE § 21.2817(2) (Tex. Dep't of Ins., Terms of Contracts).

92 TEX. INS. CODE §§ 843.342(k), 1301.137(k).

93 28 TEX. ADMIN. CODE § 21.2822 (Tex. Dep't of Ins., Administrative Penalties).

94 TEX. INS. CODE §§ 843.342(k), 1301.137(k).

95 TEX. INS. CODE §§ 843.281, 1301.066.

96 28 TEX. ADMIN. CODE § 11.901(a)(2) (Tex. Dep't of Ins., Required Provisions).

97 *See* TEX. INS. CODE §§ 843.347(a), 1301.133(b).

98 TEX. INS. CODE §§ 843.347(b), 1301.133(b); *see also* "Payment – Billed Charges" section of TDI Prompt Pay FAQs, at http://www.tdi.texas.gov/hprovider/ppsb418faq.html#payment ("the carrier must provide a response to a verification request 'without delay and as appropriate to the circumstances of the particular request, but not later than five days after the date of receipt of the request for verification'.").

99 TEX. INS. CODE §§ 843.347(d), 1301.133(d).

100 TEX. INS. CODE §§ 843.347(g), 1301.133(g).

101 TEX. INS. CODE §§ 843.347(f), 1301.133(f).

102 TEX. INS. CODE §§ 843.348, 1301.135.

103 TEX. INS. CODE §§ 843.348(a), 1301.135(b).

104 TEX. INS. CODE §§ 843.348(g), 1301.135(f).

105 TEX. INS. CODE §§ 843.342(h)(2), 1301.137(h)(2); 28 TEX. ADMIN. CODE § 21.2815(f) (Tex. Dep't of Ins., Failure to Meet the Statutory Claims Payment Period).

106 TEX. INS. CODE §843.348(h)(2), §1301.137(h)(2).

107 See TEX. CIV. PRAC. & REM. CODE § 16.004(a)(3).

108 See, *generally*, Appendix A.

109 TEX. INS. CODE §§ 843.338, 1301.103. Because the vast majority of healthcare claims nationwide are submitted electronically, this article will compare electronic claim deadlines among the 50 states plus the District of Columbia.

110 *See, generally*, Appendix A.

111 *See id.*

112 *See id.*

113 *See* ARIZ. REV. STAT. ANN. §§ 20-3101 to -3102.

114 According to a company advertising for TPPA clients, "the TPPA provides what is almost a strict-liability standard." See Healthcare Recovery Advisors website at http://healthcarerecoveryadvisors.com/.

115 *See* Sections III.D., E., and G., *supra.*

116 *See, generally*, Appendix A.

117 TEX. INS. CODE §§ 843.350, 1301.132.

118 *See* D.C. CODE ANN. § 31-3133; MD. CODE ANN., INS. § 15-1008; NEB. REV. STAT. ANN. § 44-8004.

119 *See* N.H. REV. STAT. ANN. § 415:6-i.

120 *See, generally*, Appendix A.

121 *See id.*

122 *See* Sections III.F., *supra*.

123 *See* MO. ANN. STAT. § 376.383.

124 *See, generally*, Appendix A.

125 *See id.*

126 WYO. STAT. ANN. § 26-15-124, *preempted by Moffett v. Halliburton Energy Servs*., 291 F.3d 1227 (10th Cir. 2002).

127 *See, generally*, Appendix A.

128 TEX. INS. CODE §§ 843.342(m), 1301.137(l).

129 See D.C. CODE ANN. § 31-3132; KY. REV. STAT. ANN. § 304.17A-730; MD. CODE ANN., INS. § 15-1005.

130 See D.C. CODE ANN. § 31-3132(c); MD. CODE ANN., INS. § 15-1005(f)(1).

131 UTAH CODE § 31A-26-301.6(7).

132 MO. REV. STAT. § 376.383(6).

133 *See* IND. CODE ANN. §§ 27-8-5.7-6, 27-13-36.2-4.

134 *See, e.g.*, DEL. INS. REG. 1310 §§ 1 § 2301(a); NEV. REV. STAT. § 683A.0879(2).

135 COLO. REV. STAT. § 10-16-106.6(5)(b).

136 MO. REV. STAT. § 376.383.

137 *See, generally*, Appendix A.

138 *See* LA. STAT. ANN. § 22:1860; NEB. REV. STAT. ANN. § 44-8008; N.M. STAT. ANN. § 59A-1-18.

139 TEX. INS. CODE §§ 843.342(k), 1301.137(k).

140 TEX. INS. CODE §§ 843.342(k), 1301.137(k).

141 *See* IND. CODE ANN. §§ 27-8-5.7-8, 27-13-36.2-6; KY. REV. STAT. ANN. § 304.99-123; MISS. CODE ANN. §§ 83-9-5(8); MONT. CODE ANN. § 33-18-233(2); TENN. CODE ANN. § 56-7-109(c); WASH. REV. CODE ANN. § 48.31B.035.

142 *See, generally*, Appendix A.

143 42 U.S.C. § 1395u(c)(2).

144 *See* N.H. REV. STAT. ANN. §§ 415:6-h, 415:18-k; N.J. STAT. ANN. § 17B:26-9.1; N.Y. INS. LAW § 3224-a; OHIO REV. CODE ANN. § 3901.3812.

145 IDAHO CODE § 41-5606(1), (4).

146 ME. REV. STAT. tit. 24-A, § 2436(4); MO. STAT. § 376.383(6); NEV. REV. STAT. § 695C.185(5); N.H. REV. STAT. § 415:6-h(III)(b); OKLA. STAT. tit. 36, § 1219(G); VA. CODE § 38.2-3407.15(E); W. VA. CODE § 33-45-3; WYO. STAT. § 26-15-124(c).

147 *See, generally*, Appendix A.

148 James W. Marks, *Prompt Pay Statutes for Physicians' Billing Claims: An Imperfect Remedy for a Systemic Problem*, 20 J. MED. PRAC. MGMT. 135, 137 (2004).

149 HAW. REV. STAT. § 431:13-107; IDAHO CODE § 41-5606(5); MONT. CODE § 33-18-232(3).

150 *See* N.D. CENT. CODE ANN. §§ 26.1-36-37.1 to 26.1-36-40; S.D. CODIFIED LAWS §§ 58-12-19 to 58-12-21.

151 Angela Morris, *Lawmakers Target Lawyers' 'Prompt Pay' Practice*, TEX. LAW., March 20, 2015.

Prompt-Pay Statutes – 50 States Appendix A

ALABAMA (Ala. Code § 27-1-17.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 27-1-17(a).

Penalties: 1.5% per month interest; fines up to $1,000 for each day unpaid, not to exceed $100,000 per violation. Interest is prorated daily; accrues from date overdue; payable at claim payment. § 27-1-17(c).

Other Stipulations: Notice of information is needed within 30 days; pay/deny within 21 days after receipt of information. § 27-1-17(a).

Premium Delinquency Exception/Grace Period: Matters beyond control & related directly or indirectly to the processing of claims. § 27-1-17(d)(1)(c).

Fraud and Abuse Provisions Exception: When investigation has been reported to a state or federal agency or an external review process. § 27-1-17(d)(3)(j).

Provider Timely Filing: 180 days after service rendered. § 27-1-17(d)(2).

Adjustments/Refunds/Recoupment: One year from earlier of (1) initial claim payment or (2) expiration of the provider claim filing. § 27-1-17(e)-(i). Exceptions include Medicaid and Medicare, excluding Med+C. § 27-1-17(k).

ALASKA (Alaska Stat. §§ 06.40.120, 21.36.495, 21.54.020.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 21.36.495(a)-(b).

Penalties: 15% per annum. §§ 06.40.120, 21.36.495(c)-(d).

Other Stipulations: Group plans only (1) without notice of defects in 30 days, assumed clean or (2) with notice of defects must be paid within 30 days of receipt of claim or 15 days after receipt of information. Non-group claims must be paid within 30 days with notice of acceptance or denial within 15 days. § 21.36.495(d).

Premium Delinquency Exception/Grace Period: NAIC Model.

Fraud and Abuse Provisions Exception: A clean claim is defined as a claim without a defect, impropriety, or circumstance requiring special treatment that precludes timely payment. § 21.36.495(i)(1).

Adjustments/Refunds/Recoupment: Does not prohibit a health care insurer from recovering an amount mistakenly paid to a provider or covered person. § 21.54.020(d).

ARIZONA (Ariz. Rev. Stat. Ann. §§ 20-220, 20-1347, 20-3101 to 20-3102.)

Applies to "clean claims" only; electronic claims must be paid in 60 days; written claims must be paid in 60 days. § 20-3102.

Penalties: Interest accrues from 10% one day after the payment is due. General penalties are $1,000 per violation, not to exceed $10,000 per six-month period and $5,000 per intentional violation, not to exceed $50,000 per six-month period. § 20-220(B).

Other Stipulations: Timeframe is bifurcated; 30 days to approve/deny clean claims and another 30 days after approval to pay. Notice of information is needed within 30 days; pay/deny within 21 days after receipt of information. § 20-3102.

Premium Delinquency Exception/Grace Period: Group/Blanket Disability—policy continues in force during grace period. § 20-1347.

Fraud and Abuse Provisions Exception: Clean claim is defined as a written or electronic claim that can be processed without obtaining additional information, including coordination of benefits, except in cases of fraud. §§ 20-3101(2), 20-3102(I).

Adjustments/Refunds/Recoupment: Except in cases of fraud, a health care insurer or health care provider shall not adjust or require adjustment of the claim more than one year after the health insurer has paid that claim. § 20-3102(I).

ARKANSAS (Ark. Code Ann. § 23-66-215.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days.

Penalties: 12% per year beginning on the 61st day after receipt of clean claim; 12% per year on the 46th day after receipt of other claims.

Other Stipulations: Request information within 30 days; pay/deny within 30 days of receipt of information. From the date of clean claim receipt, or receipt of needed information, to the date of adjudication, interest penalty calculated as follows: the amount of the claim payment times 12% per annum times the number of days in the delinquency payment period divided by 365.

Fraud and Abuse Provisions Exception: If information is needed to determine if there has been a fraud or a fraudulent or material misrepresentation with respect to the claim, a health carrier shall within 30 days after the receipt of the claim, notify the health claimant and shall give an explanation.

Adjustments/Refunds/Recoupment: 18-month period after the date the claim was paid; written notice required. Exceptions include coverage verification error and fraud.

CALIFORNIA (Cal. Ins. Code §§ 10123.13, 1371, AB 1455; Cal. Code Regs. tit. 28, § 1300.71.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 business days; written claims must be paid in 30 business days. § 10123.13.

Penalties: 15% per year; late payment on emergency care must include the greater of $15 for each 12-month period on a non-prorated basis or 15% per year; $10 penalty for not including interest payment with late claims payment. § 10123.13.

Fraud and Abuse Provisions Exception: Time for reimbursement of complete claim does not apply to claims about which there is evidence of fraud misrepresentation. § 1371.35.

Adjustments/Refunds/Recoupment: 365 days after the date the claim was paid; written notice required. Exceptions include fraud, wherein the provider shall reimburse the health plan within 30 working days of receipt of the notice, unless contested by the provider; if the provider does not make reimbursement, interest shall accrue at the

rate of 10% per annum beginning with the first calendar day after the 30-working day period. §§ 10123.145, 10133.66(b); Cal. Health & Safety Code § 1371.1; Cal. Code Regs. tit. 28, 1300.71(b)(5), (d)(3)-(6).

COLORADO (Colo. Rev. Stat. § 10-16-106.5.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 10-16-106.5(4)(a).

Penalties: 10% per year; after 90 days an extra penalty of 10% of the total amount of the claim is added. § 10-16-106.5(5)(a)-(b).

Other Stipulations: Request information needed within 30 days; provide requested information within 30 days; pay/deny/settle within 90 days after receipt of claim. § 10-16-106.5(5)(b).

Premium Delinquency Exception/Grace Period: Clean claim does not include a claim for payment incurred during a period for which premiums are delinquent, except as otherwise required by law. § 10-16-106.5(2).

Fraud and Abuse Provisions Exception: The 90-days time for paying claims for which additional information is needed does not apply in cases involving fraud. § 10-16-106.5(4)(c).

Adjustments/Refunds/Recoupment: Retroactive adjusting payment of a claim if the policyholder notifies the carrier of a change in eligibility of an individual and the adjustment is made within 30 days after the carrier's receipt of such notice. § 10-16-106.5(6).

CONNECTICUT (Conn. Gen. Stat. § 38a-816.)

Applies to "clean claims" only; electronic claims must be paid in 45 days; written claims must be paid in 45 days. § 38a-816.

Penalties: 15% per year. § 38a-816.

Other Stipulations: Request information needed within 30 days; pay/deny within 30 days after receipt of information. § 38a-816.

Fraud and Abuse Provisions Exception: Except when the claimant has fraudulently caused or contributed to the loss. § 38a-816(15)(A).

DELAWARE (Del. Ins. Reg. 1310 § 1.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: Maximum rate for allowable to lenders under tit. 6, § 2301(a).

Other Stipulations: Request information needed within 30 days; pay/deny within 15 days after receipt of information.

Premium Delinquency Exception/Grace Period: NAIC Model. Tit. 18, § 3307.

Fraud and Abuse Provisions Exception: Reg. 80, § 5.

Provider Timely Filing: Proof of loss must be submitted within 90 days after the date of loss. Failure to do so does not invalidate or reduce the claim, if not reasonably possible to give proof and was furnished as soon as reasonably possible. Tit. 18, § 3311, 3522.

DISTRICT OF COLUMBIA (D.C. Code §§ 31-3131 to -3136.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 31-3132.

Penalties: 1.5% per month for claims paid between 31-60 days after receipt; 2% for claims paid between 61-120 days; 2.5% for claims paid after 120 days. § 31-3132(c).

Other Stipulations: Request information is needed within 30 days; pay/deny within 30 days after receipt of information. § 31-3132.

Premium Delinquency Exception/Grace Period: Indemnity—§ 31-3512(1). HMO—§ 31-3407(a)(2)(W).

Fraud and Abuse Provisions Exception: § 31-3133(b)(2)(A).

Provider Timely Filing: 180 days from the date a covered service is rendered or the date of inpatient discharge to submit a claim for reimbursement. § 31-3132(g).

Adjustments/Refunds/Recoupment: Retroactively deny reimbursement (1) for coordination of benefits, 18-month period after the date that the health insurer paid the health care provider and (2) during the six-month period after the date that the health insurer paid the health care provider. Exceptions apply for information submitted to the health insurer that was fraudulent, improperly coded, or duplicate claims. §§ 31-3133(a)-(b), 31-3136.

FLORIDA (Fla. Stat. §§ 641.3155, 627.6131.)

Applies to "clean claims" only; electronic claims must be paid in 20 calendar days; written claims must be paid in 40 calendar days.

Penalties: 12% per year on the 21st day after receipt of clean electronic claims; 12% per year on 41st day after receipt of clean non-electronic claims; 12% per year on 91st day after receipt of unclean or contested electronic claims.

Other Stipulations: Notice of acknowledgement with 24 hours for electronic claims and 15 days for non-electronic claims; request information needed within 45 days; pay/deny contested claims within 60 days after receipt of information; all claims must be paid/denied within 120 days of receipt of claim. Section 627.613 provides 45 calendar days for payment and 10% interest penalty for subscriber submitted claims not paid promptly.

Premium Delinquency Exception/Grace Period: Grace period. NAIC Model. § 627.608.

Fraud and Abuse Provisions Exception: A claim for overpayment shall not be permitted beyond 30 months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to §§ 817.234, 641.3155(5)(b).

Provider Timely Filing: Must be mailed or electronically transferred within six months after discharge for inpatient services or the date of service for outpatient services. § 641.3155(2)(b).

Adjustments/Refunds/Recoupment: Overpayment must be submitted to a provider (MD, DO, Chiropractor, Podiatrist, and Dentist) within 12 months of the insurer or HMO's payment of the claim. Overpayment requests must be submitted for facility claims within 30 months after the insurer or HMO's payment of the claim. An

underpayment request period is limited to 12 months after the insurer or HMO's payment of the claim for MD, DO, Chiropractor, Podiatrist, and Dentist. ASO groups are excluded. §§ 627.6131(6), (11), 641.3155(5), (10).

GEORGIA (Ga. Code Ann. §§ 33-24-59.5, 33-29-3(b)(8), 33-30-6(b)(5).)

Does not apply to "clean claims" only; electronic claims must be paid in 15 business days; written claims must be paid in 30 business days.

Penalties: 12% per year based on amount paid, not days late.

Other Stipulations: Request information needed within 15 days; pay/deny within 15 days after receipt of information; a denied claim could assess a penalty of $5,000 if not denied within 15 business days.

Premium Delinquency Exception/Grace Period: Individual—§ 33-29-3 (b)(3). Group, including PPO—§ 33-30-4. NAIC Model.

Provider Timely Filing: NAIC Model. § 33-29-3(b)(5).

HAWAII (Haw. Rev. Stat. §§ 431:10A-105(5)(A), 431:13-108.)

Does not apply to "clean claims" only; electronic claims must be paid in 15 calendar days; written claims must be paid in 30 calendar days. § 431:13-108(b)-(e).

Penalties: 15% per year on all measures; interest accruing in a sum of $2.00 on a clean claim added to unpaid claim amount. § 431:13-108(h).

Other Stipulations: Contested/request for additional time notification is seven days electronic or 15 days non-electronic; specified information is needed in notice; notice is not required if reimbursement report is sent to provider monthly; pay/deny within seven days of receipt of information electronically or 30 days of receipt of information in writing. § 431:13-108(b)-(e).

Premium Delinquency Exception/Grace Period: NAIC Model. Does not include (1) claims for payment of expenses incurred during a period of time when premiums were delinquent or (2) Individual Health and Accident. Grace period. § 431:13-108(l).

Fraud and Abuse Provisions Exception: Does not include claims submitted fraudulently or that are based upon material misrepresentations. § 431:13-108(l).

Provider Timely Filing: Individual Health and Accident. NAIC Model. § 431:10A-105(5)(A).

IDAHO (Idaho Code §§ 228-22-104, 41-5601 to -5606.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 41-5602.

Penalties: 12% per year. § 28-22-104.

Other Stipulations: Interest under $4.00 is excluded; additional information requested within 30 days must be returned by the provider within 30 days, not to exceed 90 days. If less than 95% of claims were paid promptly to an individual or provider, there is a possible flat fee of $5,000. § 41-5603, -5606.

Premium Delinquency Exception/Grace Period: Insurer is not required to comply with the periods set forth, if the fee or premium entitling a beneficiary to insurance benefits has not been paid in full. § 41-5605(4).

Fraud and Abuse Provisions Exception: The time periods set forth shall not apply to claims that the insurer reasonably believes involve fraud or misrepresentation by the practitioner or facility or the beneficiary. § 41-5605(1).

Provider Timely Filing: Electronic claim within 30 days of the date on which service if a paper claim within 45 days of the date on which service. § 41-5602(2).

ILLINOIS (215 Ill. Comp. Stat. 5/357.9, 357.9a, 368a.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 days; written claims must be paid in 30 days.

Penalties: 9% per year.

Other Stipulations: Applies to all claims after receipt of written proof of loss.

Premium Delinquency Exception/Grace Period: NAIC Model. 215 ILCS 5/357.4.

Provider Timely Filing: NAIC Model. 215 ILCS 5/357.6.

Adjustments/Refunds/Recoupment: Recoupments permitted within 18 months of original payment, except for fraud or close of business. 215 Ill. Comp. Stat. 5/368d; Ill. Admin. Code tit. 50, §§ 2602.40, .50.

INDIANA (Ind. Code §§ 5-10-8.1, 12-15-27-3, 27-8-5-19, 27-8-5.7-6 to -8, 27-13-36.2.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. §§ 5-10-8.1-6, 27-8-5.7-6.

Penalties: 2% per year. § 12-15-27-3(7)(A).

Other Stipulations: Request information is needed within 30 days electronically or 45 days written. Civil penalties based on percent of claims paid timely in a calendar year are (1) up to $10,000 for 85-95%, (2) up to $100,000 for 60-84%, and (3) up to $200,000 for less than 60% of the claims are paid timely. § 27-8-5.7-8.

Premium Delinquency Exception/Grace Period: NAIC Model. § 27-8-5-19(c)(1).

Provider Timely Filing: NAIC Model. § 27-8-5-19.

Adjustments/Refunds/Recoupment: Within two years period after the date the claim was paid; written notice required. Exceptions include fraud. §§ 27-8-5.7-10 to -11, 27-13-36.2-8 to -9.

IOWA (Iowa Code §§ 507B.4, 507B.4A, ICA 191-15.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: 10% per year after the 30th day.

Other Stipulations: Applies to all claim types. Excluded claim types include FEP, BlueCard HOME and HOST, ERISA self-funded non-governmental bodies, history postings, and zero paid claims. Clean claims do not include claims that involve close of business, preexisting condition investigations, subrogation, or fraud.

Premium Delinquency Exception/Grace Period: For group-sponsored health plans, the failure to pay premiums in a timely manner would reasonably prevent an insurer from paying an otherwise clean claim within 30 days. § 507B.4A.

Fraud and Abuse Provisions Exception: Excludes claims with circumstances requiring special treatment, such as fraud or a material misrepresentation, from prompt payment requirements. § 507B.4A.

KANSAS (Kan. Stat. Ann. § 40-2440.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: 1% per month on all measures.

Other Stipulations: Pay/deny within 15 days after information receipt; applies to host claims when Kansas City Plan is the home plan and the member lives in Johnson County or Wyandotte County in Kansas.

Premium Delinquency Exception/Grace Period: NAIC Model. § 40-2203(A)(3).

Fraud and Abuse Provisions Exception: Provisions do not apply when the legitimacy of the claim is questionable, or claim was submitted fraudulently. § 40-2442(e).

Provider Timely Filing: NAIC Model. § 40-2203(A)(5).

KENTUCKY (Ky. Rev. Stat. Ann. §§ 304-17-070, 304.17A-700 to -722.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 304.17A-702.

Penalties: 12% per year for claims paid between 1-30 days after payment is due; 18% per year for claims paid between 31-60 days after payment is due; 21% per year for claims paid over 90 days after payment is due. § 304.17A-702(1), -706.

Other Stipulations: Notification of information needed within 30 days; pay/deny within 30 days after information receipt; per calendar quarter, less than 95% clean claims or less than 90% of paid claim dollar amount paid timely, the greater of $1,000 per day or 10% of unpaid claim amount fine per day; fines up to $10,000 for willful violations or pattern of repeated violations. § 304.17A-722.

Premium Delinquency Exception/Grace Period: NAIC Model. §§ 304.17-070, 304.17A-243.

Fraud and Abuse Provisions Exception: Except in cases of fraud, an insurer may only retroactively deny reimbursement to a provider during the 24-month period after the date that the insurer paid the claim submitted by the provider. § 304.17A-708(3)(a).

Provider Timely Filing: NAIC Model. § 304.17-090-110.

Adjustments/Refunds/Recoupment: Miscalculations in payments made by the insurer must be corrected and paid within 30 calendar days; after 24 months from payment date, insurer shall not correct payment errors upon provider's request. Claim refunds and overpayments—requires written notice to provider of payment made for services for an individual who was not eligible, and (1) request a refund from the provider or (2) make a recoupment of the overpayment from the provider. § 304.17A-708, -712.

LOUISIANA (La. Stat. Ann. § 22:1832 to 1860.)

Does not apply to "clean claims" only; electronic claims must be paid in 25 days; written claims must be paid in 45 days. § 22:1853.

Penalties: 12% per annum of amount due; administrative penalties up to $1,000 per violation, not to exceed $100,000 in aggregate; if the insurer knew or should have known, penalties up to $25,000, not to exceed $250,000 in aggregate in a six-month period. § 22:1860.

Other Stipulations: Within five working days from electronic claim receipt, insurer must review and notify provider of defects or reasons claim is not accepted; resubmitted claims must be paid/denied/pended within 60 days of claim receipt date. § 22:1832.

Fraud and Abuse Provisions Exception: Exception to prompt payment time frames in cases of fraud. § 22:1832.

Provider Timely Filing: Electronic Claims. Pay within 45 days of receipt, provider submitted within 45 days of date of service; pay within 60 days of receipt, any claim submitted more than 45 days after the date of service. § 22:1832.

Adjustments/Refunds/Recoupment: Recoupment of health insurance claims payments permitted. § 22:1859.

MAINE (Me. Stat. tit. 24-A, §§ 2436, 2707, 2823, 4222-B, 4303.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 days; written claims must be paid in 30 days. §§ 2436(1), 4222-B.

Penalties: 1.5% per month after the due date on claims that are unpaid or undisputed. § 2436(3).

Other Stipulations: Request information needed within 30 days; pay/deny within 30 days after receipt of information. § 2436(1-A).

Premium Delinquency Exception/Grace Period: NAIC Model. § 2707.

Provider Timely Filing: NAIC Model. § 2823.

Adjustments/Refunds/Recoupment: May only retroactively deny reimbursement during the 18-month period after the date that the carrier paid the health care provider. Exceptions apply for fraud. § 4303(10).

MARYLAND (Md. Code Ann., Ins. §§ 15-209, -1005 to -1008.)

Applies to "clean claims" only; electronic claims must be paid in 30 days; written claims must be paid in 30 days. § 15-1005(c).

Penalties: 1.5% per month from the 31st to 60th day; 2% from the 61st to 120th day; 2.5% after the 120th day. § 15-1005(f).

Other Stipulations: Applicable when CareFirst BCBS of MD is a Host for DC members. When additional information is needed, it must be requested within 30 days. § 15-1005.

Premium Delinquency Exception/Grace Period: § 15-209.

Fraud and Abuse Provisions Exception: Exceptions apply if a carrier retroactively denies reimbursement to a health care provider because the information submitted to the carrier was fraudulent. § 15-1008(e).

Provider Timely Filing: 180 days from the date a covered service is rendered to submit a claim for reimbursement for the service. § 15-1005(d)(1).

Adjustments/Refunds/Recoupment: Retroactively deny reimbursement for coordination of benefits during the 18-month period after the date that the carrier paid the health care provider; may only retroactively deny reimbursement during the six-month period after the date that the carrier paid the health care provider. Exceptions apply for fraudulent or improperly coded information or duplicate claims. § 15-1008.

MASSACHUSETTS (Mass. Gen. Laws ch. 175, §§ 108, 110(G); ch. 176A, § 8; ch. 176B, § 7; ch. 176G, § 6; ch. 1761, § 2.)

Applies to "clean claims" only; electronic claims must be paid in 45 days; written claims must be paid in 45 days.

Penalties: 1.5% per month, not to exceed 18% per year.

Other Stipulations: Applies to participating providers only; in lieu of payment, insurers can send the provider the reason for denial or list additional information needed within 45 days of receipt of claim.

Premium Delinquency Exception/Grace Period: No less than 10 days grace period. NAIC Model. § 108(3); ch. 176, § 8(b).

Fraud and Abuse Provisions Exception: Interest payments shall not apply to a claim that an insurer is investigating because of suspected fraud. Ch. 175, §§ 108(4), 110(G); ch. 176A, § 8(e); ch. 176B, § 7; ch. 176G, § 6; ch. 176, § 2(e).

Provider Timely Filing: NAIC Model. Ch. 175, § 110(G).

MICHIGAN (Mich. Comp. Laws §§ 500.2006, 1-14; 550.1403, 1-2.)

Applies to "clean claims" only; electronic claims must be paid in 45 days; written claims must be paid in 45 days.

Penalties: 12% per year.

Other Stipulations: Request information within 30 days; response by provider within 30 days of receipt of notice; pay/deny within 15 days of receipt of information; penalties calculated by number of days late times the per annum rate; civil fines of no more than $1,000 per violation, not to exceed the aggregate of $10,000 for multiple violations.

Provider Timely Filing: Provider shall bill a health plan within one year after the date of service. NAIC Model. § 500.2006(8)(f).

MINNESOTA (Minn. Stat. § 62Q.75.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: 1.5% per month or any part of the month.

Premium Delinquency Exception/Grace Period: NAIC Model. § 62A.04 Sub 2.

Fraud and Abuse Provisions Exception: A health plan administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices. § 62Q.75(e).

Provider Timely Filing: Claims must be submitted within six months from the date of service or the date the provider was informed of the responsible health plan or TPA. § 62Q.75 subds.2(e).

Adjustments/Refunds/Recoupment: Once a clean claim has been paid, the contract must provide a 12-month deadline on all adjustments and recoupments, except for close of business, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse. § 62Q.75(e).

MISSISSIPPI (Miss. Code Ann. § 83-9-5.)

Applies to "clean claims" only; electronic claims must be paid in 25 days; written claims must be paid in 35 days. § 83-9-5(1)(h)(1).

Penalties: 1.5% per month accruing after payment was due. Amounts under $1.00 can be credited. § 83-9-5(1)(h)(3).

Other Stipulations: Any claim resubmitted with supporting documentation or information requested by the insurer shall be paid within 20 days after receipt. The Insurance Commissioner may assess additional penalties. § 83-9-5(8)(a).

Premium Delinquency Exception/Grace Period: NAIC Model. § 83-9-5(1)(c).

Fraud and Abuse Provisions Exception: A clean claim does not include claims which are submitted fraudulently or that are based upon material misrepresentations. § 83-9-5(1)(h).

Provider Timely Filing: HMO—a clean claim does not include claims submitted by a provider more than 30 days after the date of service. NAIC Model. § 83-9-5(1)(h).

MISSOURI (Mo. Rev. Stat. §§ 376.383, .384, .426.)

Does not apply to "clean claims" only; electronic claims must be paid in 45 days. § 376.383(6).

Penalties: 1% per month; additional penalty of 1.0% of the unpaid claim balance if the claim is not paid or denied within 45 processing days. § 376.383(6).

Other Stipulations: Electronic date of receipt acknowledgment must be sent within 48 hours of receipt of an electronic claim; electronic or facsimile receipt acknowledgment must be sent within 30 processing days and include whether the claim was clean or additional information needed; pay/deny/request additional information within 45 days of receipt of claim; pay/deny claim within 10 days of receipt of additional information. The Insurance Commissioner can assess administrative penalties. § 376.383(2)-(6).

Premium Delinquency Exception/Grace Period: NAIC Model. § 376.426.

Fraud and Abuse Provisions Exception: Reasonable grounds to believe that a fraudulent claim is being made, shall notify the department of insurance of the fraudulent claim. § 376.383(8).

Provider Timely Filing: Non-participating healthcare providers to file a claim for a period of up to one year from the date of service; participating healthcare providers to file a claim for a period of up to six months from the date of service. § 376.384(2).

Adjustments/Refunds/Recoupment: Not more than 12 months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider. §§ 376.384(1)(3).

MONTANA (Mont. Code Ann. §§ 33-18-231 to -233, 33-22-150 to -151.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 33-18-232.

Penalties: 10% per annum; accrues from date claim payment was due; fines can be assess up to $25,000, unless insurer consistently paid 90% of outstanding amounts to claimant within 20 working days and all amounts within 30 working days of receipt. § 33-18-233.

Other Stipulations: Must pay/deny within 30 days of receipt or within 60 days if information is needed; exception for suspected fraud and reported to insurance commissioner; exception to time limits if insurer provides notice of reasons for failure to pay in full. § 33-18-232.

Fraud and Abuse Provisions Exception: Exception to pay/deny time limit applies if insurer has reasonable belief fraud has been committed and possible fraud is reported to the Insurance Commissioner; time limits for claim review and reimbursement demand is not to begin until evidence of fraud is reported to the Insurance Commissioner and the Commissioner has determined that insufficient evidence of fraud exists. § 33-18-232.

Adjustments/Refunds/Recoupment: If insurer limits time for claim submission, the same time limit applies to claim review and repayment request; if no limit for claim submission, 12 months from payment to request repayment, with exceptions; if incorrect payment caused by provider error, misrepresentation, omission, or concealment, time limit cannot exceed 24 months. Collection by offset is prohibited unless authorized by provider. §§ 33-22-150 to -151.

NEBRASKA (Neb. Rev. Stat. §§ 44-710.03, 44-8002 to -8008.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 44-8004.

Penalties: 12% per annum. The Insurance Director may impose penalties in the amount of $1,00 per violation, not to exceed an aggregate of $30,000, or more for flagrant violations. § 44-8005.

Fraud and Abuse Provisions Exception: Exception applies for fraud. § 44-8004(3)(b).

Adjustments/Refunds/Recoupment: Insurer must notify the claimant within six months of the date of the error; the notice must clearly state the nature of the error, the overpayment amount, and the three-year limitation noted below. The exception provides that, in instances of error prompted by claimant representations or nondisclosures, the insurer must notify the claimant within 15 days after the date clear, documented evidence of discovery of the error is included in its file. An insurer may use this procedure only if the claim used to adjust the first overpayment is made no later than three years after the date of the error; the date of error is the day on which the draft for benefits is issued. § 44-8008.

NEVADA (Nev. Rev. Stat. § 683A.0879.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days. § 683A.0879(1).

Penalties: Prime rate plus 6% if claim is not paid within 30 calendar days of being approved. Unclean claims that remain unpaid within 30 calendar days of receiving additional information shall be assessed at the prime rate plus 6% from the 31st day until the claim is paid. § 683A.0879(2).

Other Stipulations: If additional information is needed, it must be requested within 20 days of receipt of claim; pay/deny within 30 days of receipt of additional information. § 683A.0879(2).

Provider Timely Filing: NAIC Model. § 683A.0879.

NEW HAMPSHIRE (N.H. Rev. Stat. Ann. §§ 415:6-h, 415:18-m, 420:A:17-e, 420-j:8-b.)

Applies to "clean claims" only; electronic claims must be paid in 15 calendar days; written claims must be paid in 45 calendar days. § 415:6-h.

Penalties: 1.5% per month from the date payment was due; no interest is due if paid within 10 days of receiving notice from the provider that payment is overdue. § 415:6-h.

Other Stipulations: Notice must be sent to provider within 15 days of claim receipt when additional information is needed or claim is denied; providers may collect attorney fees upon judicial finding of bad faith; the Insurance Commissioner can impose fines for business practices in violation. § 415:6-h.

Fraud and Abuse Provisions Exception: 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. § 415:6-h(VI)(c).

Provider Timely Filing: No insurer shall be in violation of this section for any claim submitted more than 90 days after the service was rendered. § 415:6-h(VI)(b).

Adjustments/Refunds/Recoupment: Within eight months from the date of payment of the challenged claim. Exceptions provide that retroactive denial is permitted beyond the 18-month period if (1) the claim was submitted fraudulently; (2) the claim payment was incorrect because the provider or insured was already paid for the services identified in the claim; (3) the services identified in the claim were not delivered by the provider; (4) the claim payment was for services covered by Titles XVIII, XIX, or XXI of the Social Security Act; (5) the claim payment is the subject of adjustment with a different insurer, administrator, or payor and such adjustment is not affected by a contractual relationship, association, or affiliation involving claims payment, processing, or pricing; or (6) the claim payment is the subject of legal action. "Retroactive denial of a previously paid claim" means any attempt by an insurer, health service corporation, or health carrier to retroactively collect payments already made to a health care provider with respect to a claim. Notices—the provider must be notified at least 15 days in advance of the imposition of any retroactive denials of previously paid claims; the provider shall then have six months from the notification date to determine whether the insured has other appropriate insurance which was in effect on the date of service. §§ 415:6-i, :18-m; 420-A:17-e; 420-j:8-b.

NEW JERSEY (N.J. Stat. Ann. §§ 17:48-8.4, 17B:27-40.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 40 calendar days. § 17:48-8.4.

Penalties: 10% per year. § 17:48-8.4.

Other Stipulations: Request information or denied claims within 30 days of receipt; pay within 30 days of information for electronic claims or 40 days of receipt of information for other claims; include 10% per year, simple interest with overdue capitation payments; up to $10,000 civil penalties for repeated late claims payments. N.J.A.C. 11:22, 1.1 to 1.10.

Provider Timely Filing: NAIC Model. § 17B:27-40-42.

Adjustments/Refunds/Recoupment: Within 18 months after the date of the first payment on the claim is made. The exception provides that the 18-month restriction does not apply to claims that were (1) submitted fraudulently, (2) submitted by health care providers that have a pattern of inappropriate billing, or (3) subject to coordination of benefits. A payer may not seek more than one reimbursement for overpayment on a particular claim. Notices and Payer Recoupment—When a reimbursement request is submitted to the provider, the payer must provide documentation identifying the error(s) made by the payer in the processing or payment of the claim that justifies the request. § 17B:26-9.1.d(10)-(12); N.J. Admin. Code 11:22-1.6(f).

NEW MEXICO (N.M. Stat. Ann. §§ 59A-16-21.1, 59A-16C-10, 59A-22-8 to -23.)

Applies to "clean claims" only; electronic claims must be paid in 30 days; written claims must be paid in 45 days. § 59A-16-21.1.

Penalties: 1.5% per month; non-HMO penalty is 1.5 times the prime interest-lending rate; HMO penalty is 1.5% per month; administrative penalties up to $5,000 per violation or $10,000 for willful and intentional violation. § 59A-16-21.1.

Other Stipulations: Requests for additional information must be made within 30 days of receipt of electronic claims or 45 days of receipt of manual claims. § 59A-16-21.1.

Premium Delinquency Exception/Grace Period: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom. NAIC Model. § 59A-22-23.

Fraud and Abuse Provisions Exception: § 59A-16C-10.

Provider Timely Filing: NAIC Model. § 59A-22-8.

NEW YORK (N.Y. Ins. Law §§ 3221, 3224-a, 3224-b.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 3224-a(a).

Penalties: 12% per annum rate accrued on the 46th day. § 3224-a(c).

Other Stipulations: Request additional information within 30 days of claim receipt; pay/deny claim within 45 days of receipt of additional information. Per six-month period, violation values are (1) less than 0.01% of $100 per violation, (2) greater than 0.01%, but less than 0.02% of $200 per violation, (3) greater than 0.02%, but less than 0.03% of $500 per violation, (4) and greater than 0.03% of $750 per violation.

Premium Delinquency Exception/Grace Period: Premiums due under the policy shall be remitted on or before the due date thereof, with such period of grace. § 3221.

Fraud and Abuse Provisions Exception: § 3224-a(a).

Provider Timely Filing: § 3221.

Adjustments/Refunds/Recoupment: For physician healthcare claims submitted for payment after January 1, 2007, insurers and HMOs must commence overpayment recovery within 24 months of the original date payment was received by a physician, except in cases involving fraud, intentional misconduct, abusive billing, or when initiated at the request of a self-funded plan or required by a state or federal government program. Notices—other than in the case of duplicate payment recovery, insurers and HMOs must give physicians 30 days notice before engaging in overpayment recovery efforts. § 3224-b.

NORTH CAROLINA (N.C. Gen. Stat. §§ 58-2-70; 58-3-100, -200, -225; 58-65-125.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 30 calendar days.

Penalties: 18% per year after the 30th day, and/or a civil penalty. § 58-2-70.

Other Stipulations: Pay/deny/request information within 30 days of claim receipt; pay/deny within 30 days of receipt of additional information. No violation or interest owed for failure to comply caused by the person submitting the claim or matters beyond insurer's control.

Premium Delinquency Exception/Grace Period: An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant notice that the claim is pending based on nonpayment of fees or premiums. § 58-3-225(b).

Fraud and Abuse Provisions Exception: If the insurer has a reasonable basis to believe that the claim was submitted fraudulently. § 58-3-225(k).

Provider Timely Filing: 180 days after the date of the provision of care to the patient by the healthcare provider facility claims, within 180 days after the date of the patient's discharge. § 58-3-225(f).

Adjustments/Refunds/Recoupment: To the extent permitted by the contract between a healthcare provider and healthcare facility, the insurer may recover overpayments made to the provider or facility by demanding refunds or by offsetting future payments. When recouping payments, insurers must give sufficient detail so that providers and facilities can identify the specific claim against which the recoupment is being made and the reason for the recoupment. The period for which such recoveries may be made may be specified in the parties' contract. §§ 58-3-200(c), 58-3-225(h).

NORTH DAKOTA (N.D. Cent. Code § 26.1-36-4, -5, -37.1.)

Does not apply to "clean claims" only; electronic claims must be paid in 15 business days; written claims must be paid in 15 business days. § 26.1-36-37.1.

Other Stipulations: Pay/deny/request additional information within 15 days of claim receipt; pay/deny within 15 days of receipt of additional information. § 26.1-36-37.1.

Premium Delinquency Exception/Grace Period: NAIC Model. § 26.1-36-4(e).

Provider Timely Filing: NAIC Model. §§ 26.1-36-4(g), 26.1-36-5(8).

OHIO (Ohio Rev. Code Ann. §§ 3901.38, .381, .384, .388, .389, .3812; 3923.04)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 3901.381

Penalties: 18% simple interest per year; interest must be paid directly to the provider when the claim is paid and may not be used to offset other payments. § 3901.389(C).

Other Stipulations: Pay/deny/request additional information within 30 days of claim receipt; pay/deny claim no later than 45 days after receipt of claim when supporting documentation is needed; patterns of violations may result in fines of up to $100,000 for the first offense, up to $150,000 for the second offense within four years, and up to $300,000 for the third offense within seven years. § 3901.3812.

Premium Delinquency Exception/Grace Period: § 3923.04(C).

Provider Timely Filing: NAIC Model. Claims submitted later than one year from the date of service must be paid or denied within 90 days of receipt. Claims may be denied for processing if submitted later than 45 days after receiving notice from a different payer or state or federal program that it is not responsible for the claim, or the provider does not submit notice of denial from the other payer/program. §§ 3901.384, 3923.04(E).

Adjustments/Refunds/Recoupment: Within two years after payment was made; written notice required. An exception is fraud. § 3901.388.

OKLAHOMA (Okla. Stat. tit. 36, §§ 1219, 4405)

Does not apply to "clean claims" only; electronic claims must be paid in 45 calendar days; written claims must be paid in 45 calendar days. § 1219(A).

Penalties: 10% per year. § 1219(F).

Other Stipulations: Insurers must notify the insured or provider in writing within 30 calendar days of receipt of claim of defects or improprieties and information needed to correct defects. § 1219(A), (C), (D).

Provider Timely Filing: § 4405(A)(7), (G).

OREGON (Or. Rev. Stat. §§ 743.866, 743.868.)

Applies to "clean claims" only; electronic claims must be paid in 30 days; written claims must be paid in 30 days.

Penalties: 12% per annum; interest of $2.00 or less need not be paid.

Other Stipulations: Pay/deny request additional information within 30 days of claim receipt; pay/deny within 30 days of receipt of additional information; interest amounts less than $2.00 per claim is not required to be paid.

Premium Delinquency Exception/Grace Period: NAIC Model. § 743.417.

Provider Timely Filing: NAIC Model. Proof of loss must be filed within 90 days after the date of loss. § 743.429.

PENNSYLVANIA (13 Pa. Cons. Stat. tit. 40 § 991.2166.)

Does not apply to "clean claims" only; electronic claims must be paid in 45 days; written claims must be paid in 45 days.

Penalties: 10% per year.

Other Stipulations: When Capital Blue Cross, Highmark and Blue Cross of Northeastern PA are Host Plans and does not apply with Independence Blue Cross.

Premium Delinquency Exception/Grace Period: NAIC Model. 40 P.S. § 753(3).

Provider Timely Filing: NAIC Model. 40 P.S. § 753.

RHODE ISLAND (2006 R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20-47, 27-41-64.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 40 calendar days.

Penalties: 12% per year.

Other Stipulations: Request of additional information must be within 30 days of claim receipt; pay/deny within 30 days electronic claim or 40 days paper claim of receipt of additional information.

Premium Delinquency Exception/Grace Period: NAIC Model. § 27-18-3(b).

Fraud and Abuse Provisions Exception: No healthcare plan shall be in violation of this section while the claim is pending due to a fraud. §§ 27-18-61(e)(3), 27-19-52(e)(3), 27-20-47(e)(3), 27-41-64(e)(3).

Provider Timely Filing: 90 days after the service is rendered. §§ 27-18-61(e)(2), 27-19-52(e)(2), 27-20-47(e)(2), 27-41-64(e)(2).

Adjustments/Refunds/Recoupment: Recoupment or set-off of funds previously paid to the provider with respect to such claims must be completed no later than two years after the completed claim was submitted. Exceptions include (1) fraud; (2) a pattern of inappropriate billing; (3) coordination of benefits; or (4) any federal laws or regulations permitting claims review beyond the two years. §§ 27-18-64, 27-19-56, 27-20-51, 27-41-69.

SOUTH CAROLINA (S.C. Code Ann. §§ 34-31-20; 38-59-230, -250, -270; 38-71-735.)

Applies to "clean claims" only; electronic claims must be paid in 20 days; written claims must be paid in 40 days.

Penalties: 8.75% interest per annum.

Other Stipulations: Interest need not be paid when a duplicate claim is submitted within 20 days electronic claim or 40 days paper claim of the original claim submission; interest need not be paid when a participating provider balance bills a member in violation of the provider agreement; interest need not be paid when payment is made to a plan member.

Premium Delinquency Exception/Grace Period: NAIC Model. § 38-71-735(a).

Provider Timely Filing: NAIC Model. § 38-71-735(g).

SOUTH DAKOTA (S.D. Codified Laws §§ 58-12-19 to -21, 58-17-21 to -24.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 45 calendar days. § 58-12-20.

Other Stipulations: Request additional information within 30 days of claim receipt; requested information must be sent to insurer within 30 days of receipt of request. § 58-12-20.

Premium Delinquency Exception/Grace Period: The term "clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law. §§ 58-12-19 to -21.

Fraud and Abuse Provisions Exception: The term "clean claim" does not include a claim for which fraud is suspected. §§ 58-12-19 to -21.

Provider Timely Filing: NAIC Model. Proof of loss must be submitted within 90 days after the date of loss. Failure to do so does not invalidate or reduce any claim as long as it is furnished as soon as reasonably possible and not later than one year from the time proof is otherwise required. §§ 58-17-21, -24.

TENNESSEE (Tenn. Code Ann. §§ 56-7-109, -110.)

Applies to "clean claims" only; electronic claims must be paid in 21 calendar days; written claims must be paid in 30 calendar days. § 56-7-109(b)(1).

Penalties: 1% per month. § 56-7-109(b)(4).

Other Stipulations: Request information within 21 days electronic claim or 30 days paper claim of claim receipt; $10,000 penalty if 95% of unpaid clean provider claims during the year; penalty of not less than $10,000 nor more than $100,000 for 85% of unpaid provider clean claims; penalty of not less than $100,000 nor more than $200,000 for less than 60% of unpaid provider clean claims. § 56-7-109(c)(2).

Fraud and Abuse Provisions Exception: Except in cases of provider fraud, a health insurer may only retroactively deny reimbursements to the provider during the 18-month period after the date that the health insurer paid the provider submitted claim. § 56-7-110(c).

Provider Timely Filing: A clean claim does not include any claim submitted more than 90 days after the date of service. § 56-7-109(c).

Adjustments/Refunds/Recoupment: A health insurer shall not be required to correct a payment error if the provider's request for a payment correction is filed more than 18 months after the date of payment. § 56-7-110.

TEXAS (See main paper.)

UTAH (Utah Code Ann. §§ 31A-22-614, 31A-26-301.6.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 days; written claims must be paid in 30 days. § 31A-26-301.6.

Penalties: Calculate penalty by multiplying the total claim amount by total number of days late by 0.1%, for the first 90 days late. For more than 90 days late, calculate penalty by adding the 90-day late fee and the sum of the total claim amount, number of days late beyond the initial 90 days and the rate of interest under § 15-1. Also applies to providers who fail to provide information on a claim. § 31A-26-301.6.

Other Stipulations: Request additional information within 30 days of claim receipt; additional information must be provided to insurer within 30 days of receipt of request, unless a 30 day extension is requested; pay/deny claim within 20 days of receipt of additional information. § 31A-26-301.6.

Provider Timely Filing: § 31A-22-614.

Adjustments/Refunds/Recoupment: An insurer may recover any amount improperly paid (1) in accordance with the Utah Fraudulent Insurance Act or another state or federal law; (2) within 36 months for a coordination of benefits error; or (3) within 18 months for any other reason. § 31A-26-301.6(15).

VERMONT (Vt. Stat. Ann. tit. 18, § 9418.)

Does not apply to "clean claims" only; electronic claims must be paid in 30 days; written claims must be paid in 30 days.

Penalties: 12% per year.

Other Stipulations: Notice of receipt of electronic claims must be sent to providers within 24 hours of the next business day of receipt; request additional information within 30 days of claim receipt; pay/deny claim within 30 days of receipt of additional information.

Premium Delinquency Exception/Grace Period: 8 V.S.A. § 4514(7).

Fraud and Abuse Provisions Exception: 8 V.S.A. § 4065(2).

Provider Timely Filing: Tit. 8, part 3, ch. 107, subch. 1, § 4065(5).

Adjustments/Refunds/Recoupment: Retroactive denials are prohibited beyond 12 months of claims payment, except for close of business, fraud, other legal actions for recovery, or duplicate payments.

VIRGINIA (Va. Code Ann. §§ 38.2-3407.15, -3527.)

Does not apply to "clean claims" only; electronic claims must be paid in 40 days; written claims must be paid in 40 days. § 38.2-3407.15.

Penalties: 6% per year; the penalty is the rate established under §§ 38.2-3407.1 or 38.2-4306.1, the rate in the provider contract, or 6% per year after the 15th day on non-HMO-insured business. §§ 38.2-3407.1, -4306.1.

Other Stipulations: Request additional information within 30 days of claim receipt; pay/deny claim within 40 days of receipt of additional information. § 38.2-3407.15.

Premium Delinquency Exception/Grace Period: NAIC Model. § 38.2-3527.

Fraud and Abuse Provisions Exception: Exceptions apply when the claim was submitted fraudulently. § 38.2-3407.15.

Provider Timely Filing: Notice of claim. NAIC Model. § 38.2-3534.

Adjustments/Refunds/Recoupment: No retroactive denials of previously paid claim unless the carrier has provided the reason and (1) the original claim was submitted fraudulently, (2) the provider was already paid for the services or the services were not delivered, or (3) the time which has elapsed since the payment does not exceed 12 months. § 38.2-3407.15(B)(6), (7).

WASHINGTON (Wash. Rev. Code §§ 48.31B.035, 51.36.085, 284.43.321.)

Applies to "clean claims" only; electronic claims must be paid in 30 days; written claims must be paid in 30 days. § 48.31B.035.

Penalties: 1% per month on any clean claim unpaid and un-denied after 60 days. § 51.36.085.

Other Stipulations: Pay/deny within 60 days of receipt of non-clean claims. § 51.36.085.

Premium Delinquency Exception/Grace Period: NAIC Model. § 284.44.040(8).

Fraud and Abuse Provisions Exception: These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by providers, facilities, or covered persons. § 284.43.321(6).

Adjustments/Refunds/Recoupment: Refunds must be requested within 24 months from payment date, except for fraud; refunds for close of business must be requested within 36 months; providers may not request additional payments after 24 months from claim denial or 36 months from denial for close of business. §§ 48.43.600, .605.

WEST VIRGINIA (W. Va. Code §§ 33-45-2.)

Applies to "clean claims" only; electronic claims must be paid in 30 calendar days; written claims must be paid in 40 calendar days. § 33-45-2(a)(1).

Penalties: 10% per year. § 33-45-1(a)(4).

Other Stipulations: Request additional information within 30 days of receipt; second request for information within 15 days of receipt of information from first request; pay/deny within 30 days of receipt of requested information. Exceptions include when another payor is responsible, coordinating benefits, duplicate claim payment, fraud, or material misrepresentation. § 33-45-1(a)(3).

Fraud and Abuse Provisions Exception: Fraud and abuse provisions exception applies. § 33-45-2(a)(6), (7).

Adjustments/Refunds/Recoupment: Retroactive denial for duplicate claim payment or services not delivered by the provider, the provider was not entitles to reimbursement, the service provider was not covered by the health benefit plan, or the insured was not eligible for reimbursement; one-year time limit for retroactive denials, except for fraud and material misrepresentation. §§ 33-45-1(8), 33-45-2(a)(7).

WISCONSIN (Wis. Stat. §§ 628.46, 631.81.)

Applies to "clean claims" only; electronic claims must be paid in 30 days. § 628.46.

Penalties: 12% per year. § 628.46.

Provider Timely Filing: Proof of loss must be filed within one year after it was required under the policy. Failure to provide proof of loss does not reduce or invalidate a claim. §§ 628.46, 631.81.

WYOMING (Wyo. Stat. Ann. § 26-15-124.)

Does not apply to "clean claims" only; electronic claims must be paid in 45 days; written claims must be paid in 45 days. § 26-15-124(a).

Penalties: 10% per year. § 26-15-124(c).