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LC001439

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2021

A N A C T

RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Serpa, Fellela, Ackerman, and Phillips

Date Introduced: February 24, 2021

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance
2 Policies" is hereby amended by adding thereto the following section:

3 **27-18-85. Prompt processing of Medicaid claims.**

4 (a) A health insurance carrier, health benefit plan offering group, individual insurance
5 coverage, health care entity or health plan operating in this state after January 1, 2022 shall pay all
6 complete claims for covered health care services submitted by a health care provider or by a
7 policyholder within fifteen (15) calendar days following the date of receipt of a complete written
8 claim or within fifteen (15) calendar days following the date of receipt of a complete electronic
9 claim. The executive office of health and human services (EOHHS) shall establish a written
10 standard defining what constitutes a complete claim and shall distribute this standard to all
11 participating providers within three (3) months of the effective date of this section.

12 (b) If the claim is denied or pended, the health insurer, the health plan offering group,
13 individual insurance coverage, the health care entity or health plan shall have fifteen (15) calendar
14 days from receipt of the claim to notify, in writing, the health care provider or policyholder of any
15 and all reasons for denying or pending the claim and what, if any, additional information is required
16 to process the claim. No health care entity, health care insurer, or health plan may limit the time
17 period in which additional information may be submitted to complete a claim.

18 (c) If denial of a claim results from an error on the part of the health care insurer, health
19 care entity or health plan, the health insurer, the health care entity or health plan shall have fifteen

1 (15) calendar days to notify, in writing, the health care provider or policyholder of any and all errors
2 that result in denial or pending of the claim and will reprocess the claim forward for payment in
3 fifteen (15) calendar days or interest will accrue at the rate of fifteen percent (15%) per annum
4 commencing on the sixteenth day and ending on the date the payment is issued to the health care
5 provider or policyholder.

6 (d) Any claim that is resubmitted by a health care provider or policyholder shall be treated
7 by the health insurer, the health care entity or health plan pursuant to the provisions of subsection
8 (a) of this section.

9 (e)(1) A health care insurer, a health care entity or health plan which fails to notify the
10 health care provider or policyholder of any and all reasons for denying or pending the claim, and/or
11 fails to reimburse the health care provider or policyholder after receipt by the health care insurer,
12 the health care entity or health plan of a complete claim within the required timeframes shall pay
13 to the health care provider or the policyholder who submitted the claim, in addition to any
14 reimbursement for health care services provided, interest which shall accrue at the rate of fifteen
15 percent (15%) per annum commencing on the sixteenth day after receipt of a complete electronic
16 claim or on the sixteenth day after receipt of a complete written claim, and ending on the date the
17 payment is issued to the health care provider.

18 (2) A health care insurer, health care entity or health plan which fails to reimburse the
19 health care provider or policyholder after receipt by the health care insurer, the health care entity
20 or health plan of a complete claim within the required timeframes shall pay to the health care
21 provider licensed by the department of behavioral healthcare, development disabilities and
22 hospitals providing treatment to individuals with behavioral health care needs pursuant to §§ 40.1-
23 24-1, 40.1-8.5-1, and 40.1-1-13 or the policyholder who submitted the claim in addition to any
24 reimbursement for health care services provided, interest which shall accrue at the rate of twenty-
25 five percent (25%) per annum commencing on the sixteenth day after receipt of a complete
26 electronic claim or on the sixteenth day after receipt of a complete written claim, and ending on the
27 date the payment is issued to the health care provider or the policyholder.

28 SECTION 2. Chapter 27-19 of the General Laws entitled "NonProfit Hospital Service
29 Corporations" is hereby amended by adding thereto the following section:

30 **27-19-77. Prompt processing of Medicaid claims.**

31 (a) A health insurance carrier, health benefit plan offering group, individual insurance
32 coverage, health care entity or health plan operating in this state after January 1, 2022 shall pay all
33 complete claims for covered health care services submitted by a health care provider or by a
34 policyholder within fifteen (15) calendar days following the date of receipt of a complete written

1 claim or within fifteen (15) calendar days following the date of receipt of a complete electronic
2 claim. The executive office of health and human services (EOHHS) shall establish a written
3 standard defining what constitutes a complete claim and shall distribute this standard to all
4 participating providers within three (3) months of the effective date of this section.

5 (b) If the claim is denied or pended, the health insurer, the health plan offering group,
6 individual insurance coverage, the health care entity or health plan shall have fifteen (15) calendar
7 days from receipt of the claim to notify, in writing, the health care provider or policyholder of any
8 and all reasons for denying or pending the claim and what, if any, additional information is required
9 to process the claim. No health care entity, health care insurer, or health plan may limit the time
10 period in which additional information may be submitted to complete a claim.

11 (c) If denial of a claim results from an error on the part of the health care insurer, health
12 care entity or health plan, the health insurer, the health care entity or health plan shall have fifteen
13 (15) calendar days to notify, in writing, the health care provider or policyholder of any and all errors
14 that result in denial or pending of the claim and will reprocess the claim forward for payment in
15 fifteen (15) calendar days or interest will accrue at the rate of fifteen percent (15%) per annum
16 commencing on the sixteenth day and ending on the date the payment is issued to the health care
17 provider or policyholder.

18 (d) Any claim that is resubmitted by a health care provider or policyholder shall be treated
19 by the health insurer, the health care entity or health plan pursuant to the provisions of subsection
20 (a) of this section.

21 (e)(1) A health care insurer, a health care entity or health plan which fails to notify the
22 health care provider or policyholder of any and all reasons for denying or pending the claim, and/or
23 fails to reimburse the health care provider or policyholder after receipt by the health care insurer,
24 the health care entity or health plan of a complete claim within the required timeframes shall pay
25 to the health care provider or the policyholder who submitted the claim, in addition to any
26 reimbursement for health care services provided, interest which shall accrue at the rate of fifteen
27 percent (15%) per annum commencing on the sixteenth day after receipt of a complete electronic
28 claim or on the sixteenth day after receipt of a complete written claim, and ending on the date the
29 payment is issued to the health care provider.

30 (2) A health care insurer, health care entity or health plan which fails to reimburse the
31 health care provider or policyholder after receipt by the health care insurer, the health care entity
32 or health plan of a complete claim within the required timeframes shall pay to the health care
33 provider licensed by the department of behavioral healthcare, development disabilities and
34 hospitals providing treatment to individuals with behavioral health care needs pursuant to §§ 40.1-

1 24-1, 40.1-8.5-1, and 40.1-1-13 or the policyholder who submitted the claim in addition to any
2 reimbursement for health care services provided, interest which shall accrue at the rate of twenty-
3 five percent (25%) per annum commencing on the sixteenth day after receipt of a complete
4 electronic claim or on the sixteenth day after receipt of a complete written claim, and ending on the
5 date the payment is issued to the health care provider or the policyholder.

6 SECTION 3. Chapter 27-20 of the General Laws entitled "NonProfit Medical Service
7 Corporations" is hereby amended by adding thereto the following section:

8 **27-20-73. Prompt processing of Medicaid claims.**

9 (a) A health insurance carrier, health benefit plan offering group, individual insurance
10 coverage, health care entity or health plan operating in this state after January 1, 2022 shall pay all
11 complete claims for covered health care services submitted by a health care provider or by a
12 policyholder within fifteen (15) calendar days following the date of receipt of a complete written
13 claim or within fifteen (15) calendar days following the date of receipt of a complete electronic
14 claim. The executive office of health and human services (EOHHS) shall establish a written
15 standard defining what constitutes a complete claim and shall distribute this standard to all
16 participating providers within three (3) months of the effective date of this section.

17 (b) If the claim is denied or pended, the health insurer, the health plan offering group,
18 individual insurance coverage, the health care entity or health plan shall have fifteen (15) calendar
19 days from receipt of the claim to notify, in writing, the health care provider or policyholder of any
20 and all reasons for denying or pending the claim and what, if any, additional information is required
21 to process the claim. No health care entity, health care insurer, or health plan may limit the time
22 period in which additional information may be submitted to complete a claim.

23 (c) If denial of a claim results from an error on the part of the health care insurer, health
24 care entity or health plan, the health insurer, the health care entity or health plan shall have fifteen
25 (15) calendar days to notify, in writing, the health care provider or policyholder of any and all errors
26 that result in denial or pending of the claim and will reprocess the claim forward for payment in
27 fifteen (15) calendar days or interest will accrue at the rate of fifteen percent (15%) per annum
28 commencing on the sixteenth day and ending on the date the payment is issued to the health care
29 provider or policyholder.

30 (d) Any claim that is resubmitted by a health care provider or policyholder shall be treated
31 by the health insurer, the health care entity or health plan pursuant to the provisions of subsection
32 (a) of this section.

33 (e) (1) A health care insurer, a health care entity or health plan which fails to notify the
34 health care provider or policyholder of any and all reasons for denying or pending the claim, and/or

1 fails to reimburse the health care provider or policyholder after receipt by the health care insurer,
2 the health care entity or health plan of a complete claim within the required timeframes shall pay
3 to the health care provider or the policyholder who submitted the claim, in addition to any
4 reimbursement for health care services provided, interest which shall accrue at the rate of fifteen
5 percent (15%) per annum commencing on the sixteenth day after receipt of a complete electronic
6 claim or on the sixteenth day after receipt of a complete written claim, and ending on the date the
7 payment is issued to the health care provider.

8 (2) A health care insurer, health care entity or health plan which fails to reimburse the
9 health care provider or policyholder after receipt by the health care insurer, the health care entity
10 or health plan of a complete claim within the required timeframes shall pay to the health care
11 provider licensed by the department of behavioral healthcare, development disabilities and
12 hospitals providing treatment to individuals with behavioral health care needs pursuant to §§ 40.1-
13 24-1, 40.1-8.5-1, and 40.1-1-13 or the policyholder who submitted the claim in addition to any
14 reimbursement for health care services provided, interest which shall accrue at the rate of twenty-
15 five percent (25%) per annum commencing on the sixteenth day after receipt of a complete
16 electronic claim or on the sixteenth day after receipt of a complete written claim, and ending on the
17 date the payment is issued to the health care provider or the policyholder.

18 SECTION 4. Chapter 27-41 of the General Laws entitled "Health Maintenance
19 Organizations" is hereby amended by adding thereto the following section:

20 **27-41-90. Prompt processing of Medicaid claims.**

21 (a) A health insurance carrier, health benefit plan offering group, individual insurance
22 coverage, health care entity or health plan operating in this state after January 1, 2022 shall pay all
23 complete claims for covered health care services submitted by a health care provider or by a
24 policyholder within fifteen (15) calendar days following the date of receipt of a complete written
25 claim or within fifteen (15) calendar days following the date of receipt of a complete electronic
26 claim. The executive office of health and human services (EOHHS) shall establish a written
27 standard defining what constitutes a complete claim and shall distribute this standard to all
28 participating providers within three (3) months of the effective date of this section.

29 (b) If the claim is denied or pended, the health insurer, the health plan offering group,
30 individual insurance coverage, the health care entity or health plan shall have fifteen (15) calendar
31 days from receipt of the claim to notify, in writing, the health care provider or policyholder of any
32 and all reasons for denying or pending the claim and what, if any, additional information is required
33 to process the claim. No health care entity, health care insurer, or health plan may limit the time
34 period in which additional information may be submitted to complete a claim.

1 (c) If denial of a claim results from an error on the part of the health care insurer, health
2 care entity or health plan, the health insurer, the health care entity or health plan shall have fifteen
3 (15) calendar days to notify, in writing, the health care provider or policyholder of any and all errors
4 that result in denial or pending of the claim and will reprocess the claim forward for payment in
5 fifteen (15) calendar days or interest will accrue at the rate of fifteen percent (15%) per annum
6 commencing on the sixteenth day and ending on the date the payment is issued to the health care
7 provider or policyholder.

8 (d) Any claim that is resubmitted by a health care provider or policyholder shall be treated
9 by the health insurer, the health care entity or health plan pursuant to the provisions of subsection
10 (a) of this section.

11 (e)(1) A health care insurer, a health care entity or health plan which fails to notify the
12 health care provider or policyholder of any and all reasons for denying or pending the claim, and/or
13 fails to reimburse the health care provider or policyholder after receipt by the health care insurer,
14 the health care entity or health plan of a complete claim within the required timeframes shall pay
15 to the health care provider or the policyholder who submitted the claim, in addition to any
16 reimbursement for health care services provided, interest which shall accrue at the rate of fifteen
17 percent (15%) per annum commencing on the sixteenth day after receipt of a complete electronic
18 claim or on the sixteenth day after receipt of a complete written claim, and ending on the date the
19 payment is issued to the health care provider.

20 (2) A health care insurer, health care entity or health plan which fails to reimburse the
21 health care provider or policyholder after receipt by the health care insurer, the health care entity
22 or health plan of a complete claim within the required timeframes shall pay to the health care
23 provider licensed by the department of behavioral healthcare, development disabilities and
24 hospitals providing treatment to individuals with behavioral health care needs pursuant to §§ 40.1-
25 24-1, 40.1-8.5-1, and 40.1-1-13 or the policyholder who submitted the claim in addition to any
26 reimbursement for health care services provided, interest which shall accrue at the rate of twenty-
27 five percent (25%) per annum commencing on the sixteenth day after receipt of a complete
28 electronic claim or on the sixteenth day after receipt of a complete written claim, and ending on the
29 date the payment is issued to the health care provider or the policyholder.

1 SECTION 5. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

1 This act would require the prompt processing and payment of Medicaid claims for covered
2 health care services submitted by a health care provider or a policyholder within fifteen (15)
3 calendar days of receipt of a complete or electronic claim with a provision for the assessment of
4 interest for failure to notify health care providers or policyholders of denied or pending claims
5 commencing January 1, 2022.

6 This act would take effect upon passage.

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