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S T A T E O F R H O D E I S L A N D

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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This act would take effect upon passage.

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