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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. 2016

A N A C T

RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Senators Goldin, and Miller

Date Introduced: February 25, 2016

Referred To: Senate Health & Human Services

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:

27-18-82. Health care provider credentialing. – (a) For applications received on or after January 1, 2017, a health care entity or health plan operating in the state shall be required to issue a decision regarding the credentialing of a health care provider as soon as practicable, but no later than forty-five (45) calendar days after the date of receipt of a complete credentialing application.

(b) Each health care entity or health plan shall establish a written standard defining what elements constitute a complete credentialing application and shall distribute this standard with the written version of the credentialing application and make such standard available on the health care entity's or health plan's website.

(c) Each health care entity or health plan shall respond to inquiries by the applicant regarding the status of an application;

(1) Each health care entity or health plan shall provide the applicant with automated application status updates, at least once every fifteen (15) calendar days, informing the applicant of any missing application materials until the application is deemed complete; and

(2) Each health care entity or health plan shall inform the applicant within one business day that the credentialing application is complete.

(3) If the health care entity or health plan denies a credentialing application, the health

care entity or health plan shall notify the health care provider in writing and shall provide the health care provider with any and all reasons for denying the credentialing application.

(d) The effective date for billing privileges for health care providers under a particular health care entity or health plan shall be the next business day following the date of approval of the credentialing application.

(e) The office of the health insurance commissioner shall develop compliance standards and enforcement provisions consistent with this section.

(f) For the purposes of this section, the following definitions apply:

(1) "Complete credentialing application" means all the requested material has been submitted.

(2) "Date of receipt" means the date the health care entity or health plan receives the completed credentialing application whether via electronic submission or as a paper application.

(3) "Health care entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as defined in §23-17.13-2 which operates a health plan.

(4) "Health care provider" means a health care professional or a health care facility.

(5) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish health care services; and

(ii) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

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

27-19-73. Health care provider credentialing. – (a) For applications received on or after January 1, 2017, a health care entity or health plan operating in the state shall be required to issue a decision regarding the credentialing of a health care provider as soon as practicable, but no later than forty-five (45) calendar days after the date of receipt of a complete credentialing application.

(b) Each health care entity or health plan shall establish a written standard defining what elements constitute a complete credentialing application and shall distribute this standard with the written version of the credentialing application and make such standard available on the health care entity's or health plan's website.

(c) Each health care entity or health plan shall respond to inquiries by the applicant regarding the status of an application;

(1) Each health care entity or health plan shall provide the applicant with automated application status updates, at least once every fifteen (15) calendar days, informing the applicant of any missing application materials until the application is deemed complete; and

(2) Each health care entity or health plan shall inform the applicant within one business day that the credentialing application is complete.

(3) If the health care entity or health plan denies a credentialing application, the health care entity or health plan shall notify the health care provider in writing and shall provide the health care provider with any and all reasons for denying the credentialing application.

(d) The effective date for billing privileges for health care providers under a particular health care entity or health plan shall be the next business day following the date of approval of the credentialing application.

(e) The office of the health insurance commissioner shall develop compliance standards and enforcement provisions consistent with this section.

(f) For the purposes of this section, the following definitions apply:

(1) "Complete credentialing application" means all the requested material has been submitted.

(2) "Date of receipt" means the date the health care entity or health plan receives the completed credentialing application whether via electronic submission or as a paper application.

(3) "Health care entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as defined in §23-17.13-2 which operates a health plan.

(4) "Health care provider" means a health care professional or a health care facility.

(5) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish health care services; and

(ii) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

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

27-20-69. Health care provider credentialing. – (a) For applications received on or after January 1, 2017, a health care entity or health plan operating in the state shall be required to issue a decision regarding the credentialing of a health care provider as soon as practicable, but no later than forty-five (45) calendar days after the date of receipt of a complete credentialing application.

(b) Each health care entity or health plan shall establish a written standard defining what elements constitute a complete credentialing application and shall distribute this standard with the written version of the credentialing application and make such standard available on the health care entity's or health plan's website.

(c) Each health care entity or health plan shall respond to inquiries by the applicant regarding the status of an application;

(1) Each health care entity or health plan shall provide the applicant with automated application status updates, at least once every fifteen (15) calendar days, informing the applicant of any missing application materials until the application is deemed complete; and

(2) Each health care entity or health plan shall inform the applicant within one business day that the credentialing application is complete.

(3) If the health care entity or health plan denies a credentialing application, the health care entity or health plan shall notify the health care provider in writing and shall provide the health care provider with any and all reasons for denying the credentialing application.

(d) The effective date for billing privileges for health care providers under a particular health care entity or health plan shall be the next business day following the date of approval of the credentialing application.

(e) The office of the health insurance commissioner shall develop compliance standards and enforcement provisions consistent with this section.

(f) For the purposes of this section, the following definitions apply:

(1) "Complete credentialing application" means all the requested material has been submitted.

(2) "Date of receipt" means the date the health care entity or health plan receives the completed credentialing application whether via electronic submission or as a paper application.

(3) "Health care entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as defined in §23-17.13-2 which operates a health plan.

(4) "Health care provider" means a health care professional or a health care facility.

(5) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish health care services; and

(ii) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

SECTION 4. Chapter 27-41 of the General Laws entitled "Health Maintenance

Organizations" is hereby amended by adding thereto the following section:

27-41-86. Health care provider credentialing. – (a) For applications received on or after January 1, 2017, a health care entity or health plan operating in the state shall be required to issue a decision regarding the credentialing of a health care provider as soon as practicable, but no later than forty-five (45) calendar days after the date of receipt of a complete credentialing application.

(b) Each health care entity or health plan shall establish a written standard defining what elements constitute a complete credentialing application and shall distribute this standard with the written version of the credentialing application and make such standard available on the health care entity's or health plan's website.

(c) Each health care entity or health plan shall respond to inquiries by the applicant regarding the status of an application;

(1) Each health care entity or health plan shall provide the applicant with automated application status updates, at least once every fifteen (15) calendar days, informing the applicant of any missing application materials until the application is deemed complete; and

(2) Each health care entity or health plan shall inform the applicant within one business day that the credentialing application is complete.

(3) If the health care entity or health plan denies a credentialing application, the health care entity or health plan shall notify the health care provider in writing and shall provide the health care provider with any and all reasons for denying the credentialing application.

(d) The effective date for billing privileges for health care providers under a particular health care entity or health plan shall be the next business day following the date of approval of the credentialing application.

(e) The office of the health insurance commissioner shall develop compliance standards and enforcement provisions consistent with this section.

(f) For the purposes of this section, the following definitions apply:

(1) "Complete credentialing application" means all the requested material has been submitted.

(2) "Date of receipt" means the date the health care entity or health plan receives the completed credentialing application whether via electronic submission or as a paper application.

(3) "Health care entity" means a licensed insurance company or nonprofit hospital or medical or dental service corporation or plan or health maintenance organization, or a contractor as defined in §23-17.13-2 which operates a health plan.

(4) "Health care provider" means a health care professional or a health care facility.

(5) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in those plans through:

(i) Arrangements with selected providers to furnish health care services; and

(ii) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the health plan.

SECTION 5. This act shall take effect on January 1, 2017.

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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 a health care entity or health plan to issue a decision regarding the credentialing of a health care provider within forty-five (45) calendar days of receiving a complete credentialing application. This act would require a health care entity or health plan to establish a written standard defining what elements constitute a complete credentialing application and provide applicants with regular status updates throughout the credentialing process. It would also require that the office of the health insurance commissioner develop compliance standards and enforcement provisions consistent with this section.

This act would take effect on January 1, 2017.

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