

2017 -- H 5844

LC001937

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2017

A N A C T

RELATING TO INSURANCE - ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Tanzi, Casimiro, Shanley, Ruggiero, and Carson

Date Introduced: March 02, 2017

Referred To: House Finance

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18-61 of the General Laws in Chapter 27-18 entitled "Accident  
2 and Sickness Insurance Policies" is hereby amended to read as follows:

3 **27-18-61. Prompt processing of claims.**

4 (a) A health care entity or health plan operating in the state shall pay all complete claims  
5 for covered health care services submitted to the health care entity or health plan by a health care  
6 provider or by a policyholder within forty (40) calendar days following the date of receipt of a  
7 complete written claim or within thirty (30) calendar days following the date of receipt of a  
8 complete electronic claim. Each health plan shall establish a written standard defining what  
9 constitutes a complete claim and shall distribute this standard to all participating providers.

10 (b) If the health care entity or health plan denies or pends a claim, the health care entity  
11 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing  
12 the health care provider or policyholder of any and all reasons for denying or pending the claim  
13 and what, if any, additional information is required to process the claim. No health care entity or  
14 health plan may limit the time period in which additional information may be submitted to  
15 complete a claim.

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

19 (d) A health care entity or health plan which fails to reimburse the health care provider or

1 policyholder after receipt by the health care entity or health plan of a complete claim within the  
2 required timeframes shall pay to the health care provider or the policyholder who submitted the  
3 claim, in addition to any reimbursement for health care services provided, interest which shall  
4 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day  
5 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a  
6 complete written claim, and ending on the date the payment is issued to the health care provider  
7 or the policyholder.

8 (e) Exceptions to the requirements of this section are as follows:

9 (1) No health care entity or health plan operating in the state shall be in violation of this  
10 section for a claim submitted by a health care provider or policyholder if:

11 (i) Failure to comply is caused by a directive from a court or federal or state agency;

12 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating  
13 in compliance with a court-ordered plan of rehabilitation; or

14 (iii) The health care entity or health plan's compliance is rendered impossible due to  
15 matters beyond its control that are not caused by it.

16 (2) No health care entity or health plan operating in the state shall be in violation of this  
17 section for any claim: (i) initially submitted more than ninety (90) days after the service is  
18 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider  
19 received the notice provided for in subsection (b) of this section; provided, this exception shall  
20 not apply in the event compliance is rendered impossible due to matters beyond the control of the  
21 health care provider and were not caused by the health care provider.

22 (3) No health care entity or health plan operating in the state shall be in violation of this  
23 section while the claim is pending due to a fraud investigation by a state or federal agency.

24 (4) No health care entity or health plan operating in the state shall be obligated under this  
25 section to pay interest to any health care provider or policyholder for any claim if the director of  
26 business regulation finds that the entity or plan is in substantial compliance with this section. A  
27 health care entity or health plan seeking such a finding from the director shall submit any  
28 documentation that the director shall require. A health care entity or health plan which is found to  
29 be in substantial compliance with this section shall thereafter submit any documentation that the  
30 director may require on an annual basis for the director to assess ongoing compliance with this  
31 section.

32 (5) A health care entity or health plan may petition the director for a waiver of the  
33 provision of this section for a period not to exceed ninety (90) days in the event the health care  
34 entity or health plan is converting or substantially modifying its claims processing systems.

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

2 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or  
3 (iii) all services for one patient or subscriber within a bill or invoice.

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

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

9 (4) "Health care provider" means an individual clinician, either in practice independently  
10 or in a group, who provides health care services, and otherwise referred to as a non-institutional  
11 provider [or a state-licensed facility that provides mental health and/or substance abuse treatment](#)  
12 [and/or prevention services](#).

13 (5) "Health care services" include, but are not limited to, medical, mental health,  
14 substance abuse, dental and any other services covered under the terms of the specific health plan.

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

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

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

20 (7) "Policyholder" means a person covered under a health plan or a representative  
21 designated by that person.

22 (8) "Substantial compliance" means that the health care entity or health plan is processing  
23 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in  
24 subsections (a) and (b) of this section.

25 (g) Any provision in a contract between a health care entity or a health plan and a health  
26 care provider which is inconsistent with this section shall be void and of no force and effect.

27 SECTION 2. Section 27-19-52 of the General Laws in Chapter 27-19 entitled "Nonprofit  
28 Hospital Service Corporations" is hereby amended to read as follows:

29 **27-19-52. Prompt processing of claims.**

30 (a) A health care entity or health plan operating in the state shall pay all complete claims  
31 for covered health care services submitted to the health care entity or health plan by a health care  
32 provider or by a policyholder within forty (40) calendar days following the date of receipt of a  
33 complete written claim or within thirty (30) calendar days following the date of receipt of a  
34 complete electronic claim. Each health plan shall establish a written standard defining what

1 constitutes a complete claim and shall distribute this standard to all participating providers.

2 (b) If the health care entity or health plan denies or pends a claim, the health care entity  
3 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing  
4 the health care provider or policyholder of any and all reasons for denying or pending the claim  
5 and what, if any, additional information is required to process the claim. No health care entity or  
6 health plan may limit the time period in which additional information may be submitted to  
7 complete a claim.

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

11 (d) A health care entity or health plan which fails to reimburse the health care provider or  
12 policyholder after receipt by the health care entity or health plan of a complete claim within the  
13 required timeframes shall pay to the health care provider or the policyholder who submitted the  
14 claim, in addition to any reimbursement for health care services provided, interest which shall  
15 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day  
16 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a  
17 complete written claim, and ending on the date the payment is issued to the health care provider  
18 or the policyholder.

19 (e) Exceptions to the requirements of this section are as follows:

20 (1) No health care entity or health plan operating in the state shall be in violation of this  
21 section for a claim submitted by a health care provider or policyholder if:

22 (i) Failure to comply is caused by a directive from a court or federal or state agency;

23 (ii) The health care provider or health plan is in liquidation or rehabilitation or is  
24 operating in compliance with a court-ordered plan of rehabilitation; or

25 (iii) The health care entity or health plan's compliance is rendered impossible due to  
26 matters beyond its control that are not caused by it.

27 (2) No health care entity or health plan operating in the state shall be in violation of this  
28 section for any claim: (i) initially submitted more than ninety (90) days after the service is  
29 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider  
30 received the notice provided for in § 27-18-61(b); provided, this exception shall not apply in the  
31 event compliance is rendered impossible due to matters beyond the control of the health care  
32 provider and were not caused by the health care provider.

33 (3) No health care entity or health plan operating in the state shall be in violation of this  
34 section while the claim is pending due to a fraud investigation by a state or federal agency.

1 (4) No health care entity or health plan operating in the state shall be obligated under this  
2 section to pay interest to any health care provider or policyholder for any claim if the director of  
3 the department of business regulation finds that the entity or plan is in substantial compliance  
4 with this section. A health care entity or health plan seeking such a finding from the director shall  
5 submit any documentation that the director shall require. A health care entity or health plan which  
6 is found to be in substantial compliance with this section shall after this submit any  
7 documentation that the director may require on an annual basis for the director to assess ongoing  
8 compliance with this section.

9 (5) A health care entity or health plan may petition the director for a waiver of the  
10 provision of this section for a period not to exceed ninety (90) days in the event the health care  
11 entity or health plan is converting or substantially modifying its claims processing systems.

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

13 (1) "Claim" means:

14 (i) A bill or invoice for covered services;

15 (ii) A line item of service; or

16 (iii) All services for one patient or subscriber within a bill or invoice.

17 (2) "Date of receipt" means the date the health care entity or health plan receives the  
18 claim whether via electronic submission or has a paper claim.

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

22 (4) "Health care provider" means an individual clinician, either in practice independently  
23 or in a group, who provides health care services, and referred to as a non-institutional provider or  
24 a state-licensed facility that provides mental health and/or substance abuse treatment and/or  
25 prevention services.

26 (5) "Health care services" include, but are not limited to, medical, mental health,  
27 substance abuse, dental and any other services covered under the terms of the specific health plan.

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

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

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

33 (7) "Policyholder" means a person covered under a health plan or a representative  
34 designated by that person.

1 (8) "Substantial compliance" means that the health care entity or health plan is processing  
2 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in  
3 § 27-18-61(a) and (b).

4 (g) Any provision in a contract between a health care entity or a health plan and a health  
5 care provider which is inconsistent with this section shall be void and of no force and effect.

6 SECTION 3. Section 27-20-47 of the General Laws in Chapter 27-20 entitled "Nonprofit  
7 Medical Service Corporations" is hereby amended to read as follows:

8 **27-20-47. Prompt processing of claims.**

9 (a) A health care entity or health plan operating in the state shall pay all complete claims  
10 for covered health care services submitted to the health care entity or health plan by a health care  
11 provider or by a policyholder within forty (40) calendar days following the date of receipt of a  
12 complete written claim or within thirty (30) calendar days following the date of receipt of a  
13 complete electronic claim. Each health plan shall establish a written standard defining what  
14 constitutes a complete claim and shall distribute the standard to all participating providers.

15 (b) If the health care entity or health plan denies or pends a claim, the health care entity  
16 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing  
17 the health care provider or policyholder of any and all reasons for denying or pending the claim  
18 and what, if any, additional information is required to process the claim. No health care entity or  
19 health plan may limit the time period in which additional information may be submitted to  
20 complete a claim.

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

24 (d) A health care entity or health plan which fails to reimburse the health care provider or  
25 policyholder after receipt by the health care entity or health plan of a complete claim within the  
26 required timeframes shall pay to the health care provider or the policyholder who submitted the  
27 claim, in addition to any reimbursement for health care services provided, interest which shall  
28 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day  
29 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a  
30 complete written claim, and ending on the date the payment is issued to the health care provider  
31 or the policyholder.

32 (e) Exceptions to the requirements of this section are as follows:

33 (1) No health care entity or health plan operating in the state shall be in violation of this  
34 section for a claim submitted by a health care provider or policyholder if:

1 (i) Failure to comply is caused by a directive from a court or federal or state agency;

2 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating  
3 in compliance with a court-ordered plan of rehabilitation; or

4 (iii) The health care entity or health plan's compliance is rendered impossible due to  
5 matters beyond its control that are not caused by it.

6 (2) No health care entity or health plan operating in the state shall be in violation of this  
7 section for any claim: (i) initially submitted more than ninety (90) days after the service is  
8 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider  
9 received the notice provided for in § 27-18-61(b); provided, this exception shall not apply in the  
10 event compliance is rendered impossible due to matters beyond the control of the health care  
11 provider and were not caused by the health care provider.

12 (3) No health care entity or health plan operating in the state shall be in violation of this  
13 section while the claim is pending due to a fraud investigation by a state or federal agency.

14 (4) No health care entity or health plan operating in the state shall be obligated under this  
15 section to pay interest to any health care provider or policyholder for any claim if the director of  
16 the department of business regulation finds that the entity or plan is in substantial compliance  
17 with this section. A health care entity or health plan seeking such a finding from the director shall  
18 submit any documentation that the director shall require. A health care entity or health plan which  
19 is found to be in substantial compliance with this section shall after this submit any  
20 documentation that the director may require on an annual basis for the director to assess ongoing  
21 compliance with this section.

22 (5) A health care entity or health plan may petition the director for a waiver of the  
23 provision of this section for a period not to exceed ninety (90) days in the event the health care  
24 entity or health plan is converting or substantially modifying its claims processing systems.

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

26 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or  
27 (iii) all services for one patient or subscriber within a bill or invoice.

28 (2) "Date of receipt" means the date the health care entity or health plan receives the  
29 claim whether via electronic submission or has a paper claim.

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

33 (4) "Health care provider" means an individual clinician, either in practice independently  
34 or in a group, who provides health care services, and referred to as a non-institutional provider [or](#)

1 [a state-licensed facility that provides mental health and/or substance abuse treatment and/or](#)  
2 [prevention services.](#)

3 (5) "Health care services" include, but are not limited to, medical, mental health,  
4 substance abuse, dental and any other services covered under the terms of the specific health plan.

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

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

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

10 (7) "Policyholder" means a person covered under a health plan or a representative  
11 designated by that person.

12 (8) "Substantial compliance" means that the health care entity or health plan is processing  
13 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in  
14 § 27-18-61(a) and (b).

15 (g) Any provision in a contract between a health care entity or a health plan and a health  
16 care provider which is inconsistent with this section shall be void and of no force and effect.

17 SECTION 4. Section 27-41-64 of the General Laws in Chapter 27-41 entitled "Health  
18 Maintenance Organizations" is hereby amended to read as follows:

19 **27-41-64. Prompt processing of claims.**

20 (a) A health care entity or health plan operating in the state shall pay all complete claims  
21 for covered health care services submitted to the health care entity or health plan by a health care  
22 provider or by a policyholder within forty (40) calendar days following the date of receipt of a  
23 complete written claim or within thirty (30) calendar days following the date of receipt of a  
24 complete electronic claim. Each health plan shall establish a written standard defining what  
25 constitutes a complete claim and shall distribute this standard to all participating providers.

26 (b) If the health care entity or health plan denies or pends a claim, the health care entity  
27 or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing  
28 the health care provider or policyholder of any and all reasons for denying or pending the claim  
29 and what, if any, additional information is required to process the claim. No health care entity or  
30 health plan may limit the time period in which additional information may be submitted to  
31 complete a claim.

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



1 (d) A health care entity or health plan which fails to reimburse the health care provider or  
2 policyholder after receipt by the health care entity or health plan of a complete claim within the  
3 required timeframes shall pay to the health care provider or the policyholder who submitted the  
4 claim, in addition to any reimbursement for health care services provided, interest which shall  
5 accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day  
6 after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a  
7 complete written claim, and ending on the date the payment is issued to the health care provider  
8 or the policyholder.

9 (e) Exceptions to the requirements of this section are as follows:

10 (1) No health care entity or health plan operating in the state shall be in violation of this  
11 section for a claim submitted by a health care provider or policyholder if:

12 (i) Failure to comply is caused by a directive from a court or federal or state agency;

13 (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating  
14 in compliance with a court-ordered plan of rehabilitation; or

15 (iii) The health care entity or health plan's compliance is rendered impossible due to  
16 matters beyond its control, which are not caused by it.

17 (2) No health care entity or health plan operating in the state shall be in violation of this  
18 section for any claim: (i) initially submitted more than ninety (90) days after the service is  
19 rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider  
20 received the notice provided for in § 27-18-61(b); provided, this exception shall not apply in the  
21 event compliance is rendered impossible due to matters beyond the control of the health care  
22 provider and were not caused by the health care provider.

23 (3) No health care entity or health plan operating in the state shall be in violation of this  
24 section while the claim is pending due to a fraud investigation by a state or federal agency.

25 (4) No health care entity or health plan operating in the state shall be obligated under this  
26 section to pay interest to any health care provider or policyholder for any claim if the director of  
27 the department of business regulation finds that the entity or plan is in substantial compliance  
28 with this section. A health care entity or health plan seeking that finding from the director shall  
29 submit any documentation that the director shall require. A health care entity or health plan which  
30 is found to be in substantial compliance with this section shall submit any documentation the  
31 director may require on an annual basis for the director to assess ongoing compliance with this  
32 section.

33 (5) A health care entity or health plan may petition the director for a waiver of the  
34 provision of this section for a period not to exceed ninety (90) days in the event the health care

1 entity or health plan is converting or substantially modifying its claims processing systems.

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

3 (1) "Claim" means: (i) a bill or invoice for covered services; (ii) a line item of service; or  
4 (iii) all services for one patient or subscriber within a bill or invoice.

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

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

10 (4) "Health care provider" means an individual clinician, either in practice independently  
11 or in a group, who provides health care services, and is referred to as a non-institutional provider  
12 or a state-licensed facility that provides mental health and/or substance abuse treatment and/or  
13 prevention services.

14 (5) "Health care services" include, but are not limited to, medical, mental health,  
15 substance abuse, dental and any other services covered under the terms of the specific health plan.

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

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

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

21 (7) "Policyholder" means a person covered under a health plan or a representative  
22 designated by that person.

23 (8) "Substantial compliance" means that the health care entity or health plan is processing  
24 and paying ninety-five percent (95%) or more of all claims within the time frame provided for in  
25 § 27-18-61(a) and (b).

26 (g) Any provision in a contract between a health care entity or a health plan and a health  
27 care provider which is inconsistent with this section shall be void and of no force and effect.

28 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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1           This act would include a state-licensed facility that provides mental health and/or  
2 substance abuse treatment and/or prevention services in the definition of "health care provider"  
3 for the purposes of the prompt payment of health insurance claims.

4           This act would take effect upon passage.

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