

**2018 -- H 7061 SUBSTITUTE A**

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LC003167/SUB A  
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**STATE OF RHODE ISLAND**

**IN GENERAL ASSEMBLY**

**JANUARY SESSION, A.D. 2018**

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A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives Craven, McEntee, and Lombardi

Date Introduced: January 03, 2018

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~~ office of the health insurance commissioner (Commissioner) finds that the  
27 entity or plan is in substantial compliance with this section. A health care entity or health plan  
28 seeking such a finding from the ~~director~~ commissioner shall submit any documentation that the  
29 ~~director~~ commissioner shall require. A health care entity or health plan which is found to be in  
30 substantial compliance with this section shall thereafter submit any documentation that the  
31 ~~director~~ commissioner may require on an ~~annual~~ quarterly basis for the ~~director~~ commissioner to  
32 assess ongoing compliance with this 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), which 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 otherwise referred to as a non-institutional~~  
12 ~~provider~~ or a certified community mental health center, opioid treatment provider or other non-  
13 CMHC providers of approved Medicaid 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 those plans 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 (iii) All persons enrolled and approved via the BHDDH portal.

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

24 (8) "Substantial compliance" means that the ~~health care entity or health plan is processing~~  
25 ~~and paying ninety-five percent (95%) or more of all claims within the time frame provided for in~~  
26 ~~subsections (a) and (b) of this section~~ ratio by the number of claims paid or processed by a subject  
27 entity within the timeframes set forth in § 27-18-61(a) to the number of claims received, is 0.95  
28 or greater.

29 (i) To measure the level of substantial compliance with the parity statute, any health plan  
30 contracting with EOHHS must report prompt Medicaid claims processing of data by service line  
31 on a quarterly basis, and include the following information:

32 (A) Total number of claims received within the quarter;

33 (B) Total number of claims paid within statutory timeframes;

34 (C) Total number of claims paid outside of statutory timeframes;

1 (D) Average processing time (in days) for all claims paid within statutory timeframes:

2 (E) Average processing time (in days) for all claims paid outside of statutory timeframes;

3 and

4 (F) Total interest paid on claims paid outside of statutory timeframes.

5 (ii) All data must be submitted within thirty (30) days following the close of the quarter.

6 (iii) If the health plan is meeting the federal and/or contractual Medicaid reimbursement  
7 requirements, but is processing and paying behavioral health claims in an unequitable manner, it  
8 will qualify as a non-quantitative insurer practice and sanctions will be applied through the office  
9 of the health insurance commissioner.

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

12 (h) Pre-payment and timely payment. The executive office of health and human services  
13 (EOHHS) shall impose a timely claims processing and payment procedure for Medicaid services.  
14 If the health plan fails to reimburse the health care provider or policy holder within the required  
15 timeframes as outlined under subsection (a) of this section, EOHHS, office of Medicaid, will  
16 mandate under contractual agreement that the health plan execute a pre-payment reimbursement  
17 plan with agreement of the health care provider.

18 The pre-payment reimbursement plan shall require the health plan to pay a health care  
19 provider rendering opioid treatment program health home services; integrated health home  
20 services (IHH) including vocational and therapy services; assertive community treatment (ACT);  
21 mental health psychiatric rehabilitation residences (MHPRR); and substance use disorder  
22 residential treatment services.

23 Payment on a pre-payment basis shall require payment by the health plan on the first  
24 business day of each month with each payment amount equal to the average monthly payment  
25 received for individuals on the attribution list during the immediate preceding six (6) months.  
26 The health care provider and health plan shall undertake a reconciliation within one hundred  
27 eighty (180) days of the close of each quarter with any overpayment repaid by the health care  
28 provider or underpayment paid by the health plan within thirty (30) days.

29 SECTION 2. This act shall take effect upon passage.

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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF  
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RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

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1           This act would substitute the office of health insurance commissioner for the director the  
2 department business regulation as the overseer of health insurance claims, would amend the  
3 definitions of “health care provider”, “health care services”, and “substantial compliance” and  
4 would also set forth guidelines to use to determine whether substantial compliance has been met.  
5 It would also require the executive office of health and human services to impose a timely claims  
6 processing and payment procedure for Medicaid services.

7           This act would take effect upon passage.

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