SPONSOR: Sen. Mantzavinos & Rep. Bush
Sen. Walsh; Rep. Baumbach

DELAWARE STATE SENATE
152nd GENERAL ASSEMBLY

SENATE BILL NO. 143

AN ACT TO AMEND TITLE 18 OF THE DELAWARE CODE RELATING TO HEALTH INSURANCE.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 33, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3370C. Time of submitting claim for reimbursement; Coordination of benefits; Prompt payment of Claims.

(a) For purposes of this section:

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Carrier" does not mean an entity that provides a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397 et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(3) "Clean Claim" means as defined in Insurance Department Regulation 1310 [18 Del. Code Regs. § 1310] or any successor regulation relating to the prompt payment of health care claims by health insurance carriers.

(b) Time of submitting claims.

(1) Regardless of network status, a carrier shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement. Any contract between a carrier and provider that prohibits a provider from submitting a claim beyond the minimum time limit required under this section ~~shall~~ is not ~~be deemed~~ a violation of this section.

(2) A claim for reimbursement submitted within the 180-day period that is erroneously denied by a carrier due to a processing error must, upon notice by the provided to the carrier, be treated by the carrier as timely submitted and reprocessed by the carrier without requiring the provider to resubmit the claim.

(c) Requirements Related to Coordination of Benefits.

(1) A carrier that engages in coordination of benefits auditing must verify an insured's other medical coverage is effective for the date and type of service associated with an applicable claim before taking any recovery action against a provider. A carrier that fails to comply with this provision or otherwise improperly recovers payment without verifying other medical coverage is effective must reimburse the provider within 30 days of receiving notice of the improper recovery.

(2) If a carrier recovers payment for a claim from a provider as a result of coordination of benefits and thereafter receives payment for the same claim from the carrier responsible for payment through reclamation, subrogation, or otherwise must issue written notice to the provider documenting the payment from the responsible carrier within 60 days of receipt of the payment.

(3) If a carrier retroactively denies reimbursement for a service as a result of coordination of benefits, a provider has 12 months from the date of such denial to submit a claim for reimbursement to the carrier responsible for payment unless such carrier permits a longer period of time.

(d) Prompt Payment of Claims.

(1) A carrier must comply with the provisions of Insurance Department Regulation 1310 [18 Del. Code Regs. § 1310] or any successor regulation relating to the prompt payment of health care claims by health insurance carriers, and pay a clean claim, or any undisputed part thereof, no more than 30 days after receipt of the claim from a provider or policyholder.

(2) If a carrier's denial of reimbursement is found to be erroneous or improper or is otherwise overturned as part of an appeal by the provider, the carrier responsible must remit payment for the amount of the claim determined payable to the provider within 30 days of the decision on appeal.

(3) A carrier that fails to make prompt payment as required by paragraphs (1) or (2) of this subsection must pay interest on any amount remaining unpaid more than 30 days after payment is due at the monthly rate as follows:

a. 1.5% from the 31st day through the 60th day.

b. 2% from the 61st day through the 120th day.

c. 2.5% for each month after the 120th day.

Section 2. Amend Chapter 35, Title 18 of the Delaware Code by making insertions as shown by underline and deletions as shown by strikethrough as follows:

§ 3571V. Time of submitting claim for reimbursement; Coordination of benefits; Prompt payment of Claims.

(a) For purposes of this section:

(1) "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

(2) "Carrier" does not mean an entity that provides a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. §§ 1395 et seq., 1396 et seq. and 1397 et seq.), known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

(3) "Clean Claim" means as defined in Insurance Department Regulation 1310 [18 Del. Code Regs. § 1310] or any successor regulation relating to the prompt payment of health care claims by health insurance carriers.

(b) Time of submitting claims.

(1) Regardless of network status, a carrier shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement. Any contract between a carrier and provider that prohibits a provider from submitting a claim beyond the minimum time limit required under this section shall not be deemed a violation of this section.

(2) A claim for reimbursement submitted by within the 180-day period that is erroneously denied by a carrier due to a processing error must, upon notice by the provider to the carrier, be treated by the carrier as timely submitted and reprocessed by the carrier without requiring the provider to resubmit the claim.

(c) Requirements Related to Coordination of Benefits.

(1) A carrier that engages in coordination of benefits auditing must verify an insured's other medical coverage is effective for the date and type of service associated with the applicable claim under review before taking any recovery action against a provider. A carrier that fails to comply with this provision or otherwise improperly recovers payment without verifying other medical coverage is effective must reimburse the provider within 30 days of receiving notice of the improper recovery.

(2) If a carrier recovers payment for a claim from a provider as a result of coordination of benefits and thereafter receives payment or reimbursement for the same claim from the carrier responsible for payment through reclamation, subrogation, or otherwise must issue written notice to the provider documenting the payment from the responsible carrier within 60 days of receipt of the payment.

(3) If a carrier retroactively denies reimbursement for a service as a result of coordination of benefits, a provider has 12 months from the date of such denial to submit a claim for reimbursement to the carrier responsible for payment unless such carrier permits a longer period of time.

(d) Prompt Payment of Claims.

(1) A carrier must comply with the provisions of Insurance Department Regulation 1310 [18 Del. Code Regs. § 1310] or any successor regulation relating to the prompt payment of health care claims by health insurance carriers, and pay a clean claim, or any undisputed part thereof, no more than 30 days after receipt of the claim from a provider or policyholder.

(2) If a carrier's denial of reimbursement is found to be erroneous or improper or is otherwise overturned as part of an appeal by provider, the carrier responsible must remit payment for the amount of the claim determined payable to the provider within 30 days of the decision on appeal.

(3) A carrier that fails to make prompt payment as required by paragraphs (1) and (2) of this subsection shall pay interest on any amount remaining unpaid more than 30 days after payment is due at the monthly rate as follows:

a. 1.5% from the 31st day through the 60th day.

b. 2% from the 61st day through the 120th day.

c. 2.5% for each month after the 120th day.

Section 2. This Act takes effect 6 months following its enactment into law.

SYNOPSIS

This Act makes several changes intended to improve the claims payment process by health insurers. Specifically, the Act: (i) codifies the definition of "clean claim" adopted in Department of Insurance regulations; (ii) requires an insurer to treat erroneously denied claims as timely filed without the provider having to resubmit the claim; (iii) requires carriers that engaged in coordination of benefits verify an insured's other coverage is effective for the date and type of service associated with the applicable claim before taking any recovery action against a provider; (iv) requires that a carrier who recovers payment from a provider through coordination of benefits and thereafter receives reimbursement for the same claim from another insurer issue notice to the provider of the payment so that the provider may seek payment for the amount recovered; (v) allows a provider 12 months to submit a claim for reimbursement after a retroactive denial by a carrier; (vi) requires prompt payment of clean claims within 30 days and after a successful appeal by a provider from a carrier's denial of payment, with interest accruing on late payments. This Act also makes technical corrections to conform existing law to the standards of the Delaware Legislative Drafting Manual.

Author: Senator Mantzavinos