SPONSOR: Rep. Bush & Sen. Paradee
Reps. Griffith, Seigfried

HOUSE OF REPRESENTATIVES
150th GENERAL ASSEMBLY

HOUSE BILL NO. 146

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 23, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 2319 Carrier post claim adjudication audit record requests.

(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) "Post claim adjudication audit" means any audit of a claim by a carrier post payment.

(b) Except as set forth in subsection (e) of this section, medical records requests for post claim adjudication audits are limited to 400 claims for a specific episode of care in a 45 day period per provider. Any request for records pursuant to this section shall be made in writing.

(c) A provider shall have no less than 45 days and no more than 60 days from the date of the letter to submit all of the requested records.

(d) A provider shall have no less than 30 days and no more than 60 days from the receipt date of the audit result/determination letter to appeal the audit determination.

(e) This section does not apply to post claim adjudication audits which are any of the following:

(1) Based on a reasonable belief of fraud, waste, abuse or other intentional misconduct.

(2) Required by, or initiated at the request of a self-insured plan.

(3) Required by the state or federal government or a state or federal government plan.

Section 2. 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:

§ 3359A Electronic Medical (non pharmaceutical) Claims.

(a) This section shall apply to all claims for healthcare services that are submitted and are not covered by §3359 of Title 18 of the Delaware Code.

(b) 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.

(c) A carrier shall accept primary and secondary claims electronically from providers regardless of network status.

(d) A carrier shall permit a provider to receive electronic remittance advice (ERA/ 835) files for claims payments upon the completion of the necessary agreements required by the carrier.

(e) Any electronic claim shall be acknowledged by the carrier electronically no later than two business days following receipt of the claim to the entity submitting the claim.

Section 3. Amend Chapter 33, Title 18 of the Delaware Code by making insertions as shown by underline as follows:

§ 3370C Time of submitting claim for reimbursement.

(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.

(b) 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.

Section 4. Amend Chapter 35, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3571V Time of submitting claim for reimbursement.

(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.

(b) 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.

§ 3571W Electronic Medical Claims.

(a) This section shall apply to all claims for healthcare services that are submitted as part of group or blanket health insurance contracts.

(b) 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.

(c) A carrier shall accept primary and secondary claims electronically from providers regardless of network status.

(d) A carrier shall permit a provider to receive electronic remittance advice (ERA/ 835) files for claims payments upon the completion of the necessary agreements required by the carrier.

(e) Any electronic claim shall be acknowledged by the carrier electronically no later than two business days following receipt of the claim to the entity submitting the claim.

Section 6. This Act shall become effective 180 days after its enactment into law.

SYNOPSIS

This bill makes three changes to health insurers and their relationships to providers. First, it limits the number of records that can be requested by a payer from a provider for post claim adjudication audits within a specific period of time. Second, it establishes a minimum filling standard for claims to be made. And third, it details requirements for electronic medical claim submissions and payment remittance. The goal is to reduce the overall cost to collect and make the process of claims, payments, and post claim adjudication audits more efficient especially as more insurers require electronic claims.