

SENATE BILL NO. 465

BY SENATOR MCMATH

1 AN ACT

2 To amend and reenact R.S. 22:1155(C), 1832(A) and (D), 1833(B) and (E), 1834, 1838(F)
3 and (G), 1853(A), the introductory paragraph of 1853(B)(1), and 1853(C) and (D),
4 1854(A), the introductory paragraph of 1854(B), and 1854(C), and R.S. 33:5151(A)
5 and to enact R.S. 22:1839, relative to payments to healthcare providers; to provide
6 for recoupment of dental service claims payments; to provide for standards for
7 receipt and processing of claims; to provide for recoupment of health insurance
8 claims payments; to prohibit waivers; to provide for payments to pharmacists and
9 pharmacies; to provide for payment of individual policies of certain public
10 employees under certain circumstances; and to provide for related matters.

11 Be it enacted by the Legislature of Louisiana:

12 Section 1. R.S. 22:1155(C), 1832(A) and (D), 1833(B) and (E), 1834, 1838(F) and
13 (G), 1853(A), the introductory paragraph of 1853(B)(1), and 1853(C) and (D), 1854(A), the
14 introductory paragraph of 1854(B), and 1854(C) are hereby amended and reenacted and R.S.
15 22:1839 is hereby enacted to read as follows:

16 §1155. Denial of claims; appeal; prior authorization; preexisting conditions

17 * * *

18 C. ~~Any recoupment by a dental service contractor shall be in accordance with~~
19 ~~R.S. 22:1838. A dental service contractor shall not retroactively deny, adjust, or~~
20 ~~seek recoupment or refund of a paid claim for dental services submitted by a~~
21 ~~dental provider for dental services rendered in good faith and pursuant to the~~
22 ~~benefit plan for any reason after the expiration of eighteen months from the~~
23 ~~date the initial claim was paid.~~ The contractor shall not recoup a claim solely due
24 to a patient's loss of coverage or ineligibility if, at the time of treatment, the
25 contractor erroneously confirms coverage and eligibility, but had sufficient
26 information available to it indicating that the patient was no longer covered or was
27 ineligible for coverage.

* * *

§1832. Standards for receipt and processing of nonelectronic claims

A.(1) Any nonelectronic claim by a ~~health care~~ **healthcare** provider under a contract with a health insurance issuer, for provision of ~~health care~~ **healthcare** services, submitted by the provider or its agent within ~~forty-five days of the date of service, or date of discharge from a health care facility or institution,~~ **the period of time set forth by the health insurance issuer for the timely filing of claims or resubmitted because the original claim was not an accepted claim or not a clean claim** shall be paid, denied, or pended not more than ~~forty-five~~ **thirty calendar** days from the date upon which a nonelectronic clean claim is received by the issuer or its agent, ~~unless it is not payable under the terms of the applicable contract of health insurance coverage or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.~~

(2) Any nonelectronic claim by a ~~health care~~ **healthcare** provider under a contract with a health insurance issuer, for provision of ~~health care~~ **healthcare** services **that have prior authorization by the health insurance issuer**, submitted by the provider or its agent ~~more than forty-five days after the date of service, or date of discharge from a health care facility or institution, or resubmitted because the original claim was not an accepted claim or not a clean claim~~ **within the period of time set forth by the health insurance issuer for the timely filing of claims** shall be paid, denied, or pended not more than ~~sixty~~ **ten calendar** days from the date upon which a nonelectronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance ~~or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard.~~

(3) Any other nonelectronic claim for health insurance coverage benefits submitted for payment by an enrollee or insured or by a noncontracted ~~health care~~ **healthcare** provider rendering covered ~~health care~~ **healthcare** services, or by the provider's agent, shall be paid, denied, or pended not more than forty-five days from the date upon which a nonelectronic clean claim is received by the issuer or its agent,

1 unless it is not payable under the terms of the applicable contract of insurance ~~or~~
2 ~~unless just and reasonable grounds exist such as would put a reasonable and prudent~~
3 ~~businessman on his guard.~~

4 (4) For purposes of this Subsection, the issuer shall either provide written
5 notice to the provider **within two business days** that a claim is pended or allow the
6 provider ~~Internet~~ **internet** access to such information.

7 ~~(5) Just and reasonable grounds, as used in this Subsection, shall include but~~
8 ~~not be limited to determination of whether the enrollee or insured was eligible for~~
9 ~~health insurance coverage on the date health care services were rendered.~~

10 * * *

11 D. The provisions of this Subpart shall ~~not~~ apply to the Office of Group
12 Benefits.

13 §1833. Standards for receipt and processing of electronic claims

14 * * *

15 B.(1) Any electronic claim **for healthcare services that have prior**
16 **authorization by the health insurance issuer** shall be paid, denied, or pended not
17 more than ~~twenty-five~~ **ten** days from the date upon which an electronic clean claim
18 is electronically received by the health insurance issuer or its agent, unless it is not
19 payable under the terms of the applicable contract of insurance ~~or unless just and~~
20 ~~reasonable grounds exist such as would put a reasonable and prudent businessman~~
21 ~~on his guard.~~ **Any electronic claim for healthcare services that do not have prior**
22 **authorization by the health insurance issuer shall be paid, denied, or pended not**
23 **more than twenty-five days from the date upon which an electronic clean claim**
24 **is electronically received by the health insurance issuer or its agent, unless it is**
25 **not payable under the terms of the applicable contract of insurance.**

26 (2) For purposes of this Subsection, the issuer shall either provide written
27 notice to the provider **within two business days** that a claim is pended or allow the
28 provider ~~Internet~~ **internet** access to such information.

29 ~~(3) Just and reasonable grounds, as used in this Subsection, shall include but~~
30 ~~not be limited to determination of whether the enrollee or insured was eligible for~~

1 ~~health insurance coverage on the date health care services were rendered.~~

2 * * *

3 E. The provisions of this Subpart shall ~~not~~ apply to the Office of Group
4 Benefits.

5 §1834. Remittance advice; ~~thirty-day~~ payment standard; limitations on claim filing
6 and audits

7 A. Each remittance advice generated by a health insurance issuer or its agent
8 to a ~~health care~~ **healthcare** provider or its agent shall include the following
9 information, if known at that time, clearly identified for each claim listed:

- 10 (1) The name of the enrollee or insured.
- 11 (2) Unique enrollee or insured identification number.
- 12 (3) Patient claim number or patient account number.
- 13 (4) Date of service.
- 14 (5) Total provider charges.
- 15 (6) Health insurance issuer contractual discount amount.
- 16 (7) Enrollee or insured liability, specifying any coinsurance, deductible,
17 copayment, or noncovered amount.
- 18 (8) Amount paid by health insurance issuer.
- 19 (9) Amount adjusted by health insurance issuer and the reason for adjustment.
- 20 (10) Amount denied and the reason for denial.

21 ~~B. A health insurance issuer may elect to utilize a thirty-day payment~~
22 ~~standard for compliance with R.S. 22:1832 and 1833 by providing written notice to~~
23 ~~the commissioner. Such notice shall be in a form prescribed by the commissioner and~~
24 ~~shall remain in effect until withdrawn in writing as may be required by the~~
25 ~~commissioner. Any health insurance issuer electing to utilize a thirty-day payment~~
26 ~~standard shall continue to comply with all other requirements of this Subpart.~~

27 ~~C.~~**B.** A health insurance issuer that prescribes the period of time that a ~~health~~
28 ~~care~~ **healthcare** provider under contract for provision of ~~health care~~ **healthcare**
29 services has to submit a claim for payment under R.S. 22:1832 or 1833 shall have
30 the same prescribed period of time following payment of such claim to perform any

1 review or audit for purposes of reconsidering the validity of such claim.

2 ~~D.C.~~ Notwithstanding any other provision of law to the contrary, no health
3 insurance insurer shall limit the right of a rural hospital to receive payment for
4 covered ~~health care~~ **healthcare** services as long as a claim for payment of such
5 services is submitted within one year after the date on which the rural hospital
6 provided the services.

7 ~~E.D.~~ Notwithstanding any other provision of law to the contrary, for health
8 services rendered in good faith and pursuant to the benefit plan, no health insurance
9 issuer shall retroactively deny payment or recoup any monies paid beyond ninety
10 days from the expiration of the allowable ~~thirty-day~~ period for the payment of any
11 claim when the denial or recoupment is based on a determination that the insured
12 was no longer covered under the plan at the time of the service.

13 ~~F.E.~~ The provision described in ~~Subsection E~~ **Subsection D** of this Section
14 shall ~~not~~ apply to the Office of Group Benefits ~~or~~ **and** to the claims of Office of
15 Group Benefits enrollees administered by health insurance issuers.

16 ~~G.F.~~ In order to be eligible for credit of premium by a health insurance issuer,
17 an employer that contracts with a health insurance issuer for the issuer's provision
18 or administration of health benefits shall provide notice to the health insurance issuer
19 that an employee, dependent, or retiree is no longer eligible for coverage in the group
20 benefit plan within ninety days of such ineligibility.

21 * * *

22 §1838. Recoupment of health insurance claims payments

23 * * *

24 F.(1) A health insurance issuer shall not retroactively deny, adjust, or seek
25 recoupment or refund of a paid claim for healthcare expenses submitted by a
26 healthcare provider for healthcare services rendered in good faith and pursuant to the
27 benefit plan for any reason after the expiration of ~~eighteen~~ **twelve** months from the
28 date the initial claim was paid.

29 (2) This Subsection shall not be construed to supersede any provision of law
30 that prescribes a time period less than ~~eighteen~~ **twelve** months for the retroactive

1 denial of payment or recoupment of monies paid for a claim or the reconsideration
 2 of the validity of a claim.

3 G. The provisions of this Section shall ~~not~~ apply to the Office of Group
 4 Benefits.

5 **§1839. Waiver prohibited**

6 **The provisions of this Subpart shall not be waived by contract. Any**
 7 **attempted waiver shall be void.**

8 * * *

9 §1853. Nonelectronic claims submission **and prompt processing standards**

10 A.(1) Any nonelectronic claim for payment for prescription drugs, other
 11 products and supplies, and pharmacist services submitted by a pharmacist or
 12 pharmacy **to a health insurance issuer or pharmacy benefit manager** within forty-
 13 five days of the date of service under a contract for provision of covered benefits
 14 ~~with a health insurance issuer~~ shall be paid not more than ~~forty-five~~ **twenty-one** days
 15 from the date upon which a correctly completed uniform claim form is furnished;
 16 ~~unless just and reasonable grounds exist such as would put a reasonable and prudent~~
 17 ~~businessman on his guard.~~

18 (2) Any nonelectronic claim for payment for prescription drugs, other
 19 products and supplies, and pharmacist services submitted by a pharmacist or
 20 pharmacy under a contract for provision of covered benefits with a health insurance
 21 issuer more than forty-five days after the date of service or resubmitted because the
 22 original claim was incomplete shall be paid not more than ~~sixty~~ **thirty** days from the
 23 date upon which a correctly completed uniform claim form is furnished, ~~unless just~~
 24 ~~and reasonable grounds exist such as would put a reasonable and prudent~~
 25 ~~businessman on his guard.~~

26 (3) Any other nonelectronic claim for payment for prescription drugs, other
 27 products and supplies, and pharmacist services, whether submitted for payment by
 28 an insured or enrollee or submitted by a pharmacist or pharmacy rendering covered
 29 services that are not otherwise payable to the pharmacist or pharmacy under contract
 30 with the health insurance issuer, shall be paid not more than thirty days from the date

1 upon which a correctly completed uniform claim form is furnished to the health
2 insurance issuer, ~~unless just and reasonable grounds exist such as would put a~~
3 ~~reasonable and prudent businessman on his guard.~~

4 B.(1) Health insurance issuers **and pharmacy benefit managers** shall have
5 appropriate handling procedures approved by the department for the acceptance of
6 nonelectronic claim submissions. Such procedures shall include:

7 * * *

8 C. Health insurance issuers **and pharmacy benefit managers** shall establish
9 appropriate procedures approved by the department to assure that any claimant who
10 is not paid within the time frames specified in this Section receives a late payment
11 adjustment equal to one percent of the amount due. For any period greater than
12 twenty-five days following the time frames specified in this Section, the health
13 insurance issuer shall pay an additional late payment adjustment equal to one percent
14 of the unpaid balance due for each month or partial month that such claim remains
15 unpaid.

16 D. Health insurance issuers **and pharmacy benefit managers** shall have
17 appropriate procedures approved by the department to assure compliance with this
18 Subpart. Such procedures shall include but shall not be limited to a plan for the
19 acceptance of nonelectronic claim submissions to document the actual date of receipt
20 and to prevent the loss of such claims.

21 §1854. Electronic claim submission standards

22 A. Any claim for payment for covered prescription drugs, other products and
23 supplies, and pharmacist services submitted by a pharmacist or pharmacy to a health
24 insurance issuer **or pharmacy benefit manager** as an electronic claim that is
25 electronically adjudicated shall be paid not later than the fifteenth day after the date
26 on which the claim was electronically adjudicated. If the governor declares a state
27 of emergency pursuant to R.S. 29:724, the time period prescribed in this Subsection
28 shall be interrupted during the continuance of the state of emergency for any claims
29 office which is located in the territorial limits of the declared state of emergency.

30 B. Health insurance issuers **and pharmacy benefit managers** shall have

1 appropriate handling procedures approved by the department for the acceptance of
 2 electronic claim submissions. Such procedures shall include:

3 * * *

4 C. Health insurance issuers and pharmacy benefit managers shall establish
 5 appropriate procedures approved by the department to assure that any claimant who
 6 is not paid within the time frame specified in this Section receives a late payment
 7 adjustment equal to one percent of the amount due. For any period greater than
 8 twenty-five days following the time frames specified in this Section, the health
 9 insurance issuer shall pay an additional late payment adjustment equal to one percent
 10 of the unpaid balance due for each month or partial month that such claim remains
 11 unpaid.

12 Section 2. R.S. 33:5151(A) is hereby amended and reenacted to read as follows:

13 §5151. Power to contract for group insurance; premiums

14 A.(1) Any municipality or political subdivision of the state may make
 15 contracts of insurance with any insurance company legally authorized to do business
 16 in this state insuring their employees and officials under policies of group insurance
 17 covering hospitalization, and retirement, for such employees and officials, and may
 18 agree to match the payments of the employees and officials for the premiums or
 19 charges for any such contracts payable out of the funds of such municipality or
 20 political subdivision, respectively.

21 **(2) Notwithstanding the provisions of Paragraph (1) of this Subsection,**
 22 **any municipality or political subdivision of this state with less than two**
 23 **employees or officials may do either of the following:**

24 **(a) Make contracts of insurance with any insurance company legally**
 25 **authorized to do business in this state insuring their employee or official under**
 26 **policies of individual insurance covering hospitalization, and retirement, for the**
 27 **employee or official, and may agree to match the payments of the employee and**
 28 **official for the premiums or charges for any such contracts payable out of the**
 29 **funds of the municipality or political subdivision, respectively.**

30 **(b) Reimburse the employee or official for payment toward any policies**

1 of individual insurance covering hospitalization, and retirement, for the
2 employee or official.

3 * * *

4 Section 3. This Act shall become effective on January 1, 2027.

PRESIDENT OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____