

2026 Regular Session

SENATE BILL NO. 465

BY SENATOR MCMATH

HEALTH CARE. Provides for payments to healthcare providers. (8/1/26)

1 AN ACT

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

9 Be it enacted by the Legislature of Louisiana:

10 Section 1. R.S. 22:1832(A) and (D), 1833(B) and (E), 1834, 1838(F) and (G),
11 1853(A), the introductory paragraph of 1853(B)(1), and 1853(C) and (D), 1854(A), the
12 introductory paragraph of 1854(B), and 1854(C) are hereby amended and reenacted and R.S.
13 22:1839 is hereby enacted to read as follows:

14 §1832. Standards for receipt and processing of nonelectronic claims

15 A.(1) Any nonelectronic claim by a ~~health care~~ **healthcare** provider under
16 a contract with a health insurance issuer, for provision of ~~health care~~ **healthcare**
17 services, submitted by the provider or its agent within ~~forty-five days of the date of~~

1 ~~service, or date of discharge from a health care facility or institution,~~ **the period of**
 2 **time set forth by the health insurance issuer for the timely filing of claims or**
 3 **resubmitted because the original claim was not an accepted claim or not a clean**
 4 **claim** shall be paid, denied, or pending not more than ~~forty-five~~ **thirty calendar** days
 5 from the date upon which a nonelectronic clean claim is received by the issuer or its
 6 agent, ~~unless it is not payable under the terms of the applicable contract of health~~
 7 ~~insurance coverage or unless just and reasonable grounds exist such as would put a~~
 8 ~~reasonable and prudent businessman on his guard.~~

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

21 (3) Any other nonelectronic claim for health insurance coverage benefits
 22 submitted for payment by an enrollee or insured or by a noncontracted ~~health care~~
 23 **healthcare** provider rendering covered health care services, or by the provider's
 24 agent, shall be paid, denied, or pending not more than forty-five days from the date
 25 upon which a nonelectronic clean claim is received by the issuer or its agent, unless
 26 it is not payable under the terms of the applicable contract of insurance ~~or unless just~~
 27 ~~and reasonable grounds exist such as would put a reasonable and prudent~~
 28 ~~businessman on his guard.~~

29 (4) For purposes of this Subsection, the issuer shall either provide written

1 notice to the provider **within two business days** that a claim is pended or allow the
2 provider Internet access to such information.

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

6 * * *

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

9 §1833. Standards for receipt and processing of electronic claims

10 * * *

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

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

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

28 * * *

29 E. The provisions of this Subpart shall ~~not~~ apply to the Office of Group

1 Benefits.

2 §1834. Remittance advice; ~~thirty-day~~ payment standard; limitations on claim filing
3 and audits

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

7 (1) The name of the enrollee or insured.

8 (2) Unique enrollee or insured identification number.

9 (3) Patient claim number or patient account number.

10 (4) Date of service.

11 (5) Total provider charges.

12 (6) Health insurance issuer contractual discount amount.

13 (7) Enrollee or insured liability, specifying any coinsurance, deductible,
14 copayment, or noncovered amount.

15 (8) Amount paid by health insurance issuer.

16 (9) Amount adjusted by health insurance issuer and the reason for adjustment.

17 (10) Amount denied and the reason for denial.

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

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

29 ~~D.~~**C.** Notwithstanding any other provision of law to the contrary, no health

1 insurance insurer shall limit the right of a rural hospital to receive payment for
 2 covered ~~health care~~ **healthcare** services as long as a claim for payment of such
 3 services is submitted within one year after the date on which the rural hospital
 4 provided the services.

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

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

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

19 * * *

20 §1838. Recoupment of health insurance claims payments

21 * * *

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

27 (2) This Subsection shall not be construed to supersede any provision of law
 28 that prescribes a time period less than ~~eighteen~~ **twelve** months for the retroactive
 29 denial of payment or recoupment of monies paid for a claim or the reconsideration

1 of the validity of a claim.

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

4 **§1839. Waiver prohibited**

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

7 * * *

8 §1853. Nonelectronic claims submission **and prompt processing standards**

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

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

25 (3) Any other nonelectronic claim for payment for prescription drugs, other
26 products and supplies, and pharmacist services, whether submitted for payment by
27 an insured or enrollee or submitted by a pharmacist or pharmacy rendering covered
28 services that are not otherwise payable to the pharmacist or pharmacy under contract
29 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.

1 B. Health insurance issuers **and pharmacy benefit managers** shall have
 2 appropriate handling procedures approved by the department for the acceptance of
 3 electronic claim submissions. Such procedures shall include:

4 * * *

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

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Senate Legislative Services. The keyword, summary, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

DIGEST

SB 465 Reengrossed

2026 Regular Session

McMath

Present law provides for the standards for receipt and processing of claims by health insurance issuers.

Present law provides that nonelectronic claims by a provider under contract submitted within 45 days of the date of service or discharge shall be paid, denied, or pending within 45 days.

Proposed law provides that nonelectronic claims submitted during the time period set forth by the insurer shall be paid, denied, or pending within 30 calendar days.

Present law provides that nonelectronic claims submitted more than 45 days after the day of service shall be paid, denied, or pending, within 60 days.

Proposed law provides that nonelectronic claims that have been prior authorized and submitted within the time period set forth by the insurer shall be paid, denied, or pending within ten calendar days.

Present law requires electronic claims to be paid, denied, or pending within 25 days.

Proposed law requires prior authorized electronic claims to be paid within 10 days and for electronic claims that have not been preauthorized to be paid within 25 days.

Present law requires health insurance issuers to provide notice to providers when a claim is pending.

Proposed law requires the notice to be provided within two business days.

Present law authorized a health insurance issuer to utilize a 30 day payment standard by providing notice to the commissioner.

Proposed law repeals present law.

Present law prohibits a health insurance issuer from retroactively denying, adjusting, or seeking recoupment or refund of a paid claim submitted in good faith after 18 months.

Proposed law prohibits recoupment after 12 months.

Present law exempts the office of group benefits from the provisions of present law.

Proposed law makes the provisions of present law and proposed law applicable to the office of group benefits.

Proposed law prohibits the waiver of the payment requirements through contract.

Present law provides that payments of nonelectronic claims submitted by a pharmacist or pharmacy within 45 days shall be paid within 45 days.

Proposed law provides that the claim shall be paid within 21 days.

Present law provides that payments of nonelectronic claims submitted by a pharmacist or pharmacy after 45 days shall be paid within 60 days.

Proposed law provides that the payment shall be made within 30 days.

Proposed law removes provisions relative to just and reasonable grounds for noncompliance.

Effective August 1, 2026.

(Amends R.S. 22:1832(A) and (D), 1833(B) and (E), 1834, 1838(F) and (G), 1853(A), 1853(B)(1)(intro para), and 1853(C) and (D), 1854(A), 1854(B)(intro para), and 1854(C); adds R.S. 22:1839)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Make technical changes.

Committee Amendments Proposed by Senate Committee on Finance to the engrossed bill

1. Reduces the time limit in which a health insurance provider is prohibited from retroactively denying, adjusting, or seeking recoupment or refund of a paid claim submitted in good faith from 18 months to 12 months.