SLS 26RS-680 **RE-REENGROSSED**

2026 Regular Session

SENATE BILL NO. 465

BY SENATOR MCMATH

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

AN ACT

To amend and reenact R.S. 22:1155(C), 1832(A) and (D), 1833(B) and (E), 1834, 1838(F) and (G), 1853(A), the introductory paragraph of 1853(B)(1), and 1853(C) and (D), 1854(A), the introductory paragraph of 1854(B), and 1854(C) and to enact R.S. 22:1839, relative to payments to healthcare providers; to provide for recoupment of dental service claims payments; to provide for standards for receipt and processing of claims; to provide for recoupment of health insurance claims payments; to prohibit waivers; to provide for payments to pharmacists and pharmacies; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

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

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

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C. ~~Any recoupment by a dental service contractor shall be in accordance with~~

Coding: Words which are ~~struck through~~ are deletions from existing law; words in **boldface type and underscored** are additions.

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

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§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, 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~~.

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

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

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

§1833. Standards for receipt and processing of electronic claims

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B.(1) Any electronic claim **for healthcare services that have prior authorization by the health insurance issuer** shall be paid, denied, or pended not more than ~~twenty-five~~ **ten** days from the date upon which an electronic clean claim is electronically received by the health insurance 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~~. **Any electronic claim for healthcare services that do not have prior authorization by the health insurance issuer shall be paid, denied, or pended not more than twenty-five days from the date upon which an electronic claim is electronically received by the health insurance issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance.**

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

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

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

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

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

(1) The name of the enrollee or insured.

(2) Unique enrollee or insured identification number.

(3) Patient claim number or patient account number.

(4) Date of service.

(5) Total provider charges.

(6) Health insurance issuer contractual discount amount.

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

(8) Amount paid by health insurance issuer.

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

(10) Amount denied and the reason for denial.

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

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

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

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

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

~~G.~~**F.** In order to be eligible for credit of premium by a health insurance issuer, an employer that contracts with a health insurance issuer for the issuer's provision

or administration of health benefits shall provide notice to the health insurance issuer that an employee, dependent, or retiree is no longer eligible for coverage in the group benefit plan within ninety days of such ineligibility.

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§1838. Recoupment of health insurance claims payments

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

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

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

§1839. Waiver prohibited

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

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

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

~~businessman on his guard~~.

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

(3) Any other nonelectronic claim for payment for prescription drugs, other products and supplies, and pharmacist services, whether submitted for payment by an insured or enrollee or submitted by a pharmacist or pharmacy rendering covered services that are not otherwise payable to the pharmacist or pharmacy under contract with the health insurance issuer, shall be paid not more than thirty days from the date upon which a correctly completed uniform claim form is furnished to the health insurance issuer~~, unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard~~.

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

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

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

§1854. Electronic claim submission standards

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

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

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C. Health insurance issuers **and pharmacy benefit managers** shall establish appropriate procedures approved by the department to assure that any claimant who is not paid within the time frame specified in this Section receives a late payment adjustment equal to one percent of the amount due. For any period greater than twenty-five days following the time frames specified in this Section, the health insurance issuer shall pay an additional late payment adjustment equal to one percent of the unpaid balance due for each month or partial month that such claim remains 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 Re-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 pended within 45 days.

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

Present law requires electronic claims to be paid, denied, or pended 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 pended.

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.

Proposed law prohibits a dental insurance contractor from retroactively denying, adjusting, or seeking recoupment or refund of a paid claim submitted in good faith after 18 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. 22:1155(C), 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.

Senate Floor Amendments to reengrossed bill

1. Provides that a dental service contractor is prohibited after the passage of 18 months from retroactively denying, adjusting, or seeking recoupment or refund of a paid claim submitted in good faith.

2. Make technical changes.