**PROMPT PAYMENT COMPLIANCE MODEL LEGISLATION**

An act requiring health insurers to file reports with the State containing information on a health insurer’s compliance with the State’s prompt payment laws and the penalties that have been imposed as a result of enforcement of such laws.

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**SECTION 1. SHORT TITLE**

This Act may be cited as the “Prompt Payment Accountability and Transparency Act of 20\_\_”.

**SECTION 2. FINDINGS.**[[1]](#footnote-1) The Legislature finds that—

1. providers of health care and behavioral health services depend on timely payment of claims by health insurers, and needless delays in reimbursement from insurers put health care providers at financial risk, jeopardizing access to care for communities throughout the State;
2. enforcement of state prompt pay laws, which require health insures to timely process and pay claims, depends largely on providers filing complaints and appeals, or upon extensive and complex review of insures’ conduct by regulators;[[2]](#footnote-2)
3. regulators and providers do not have a clear picture of insurers’ capacity to comply with prompt pay laws; and
4. to ensure compliance with state prompt pay laws, health insurers should collect and report relevant data to the state.

**SECTION 3. DEFINITIONS.** For purposes of this Act, the following terms shall have the meanings defined below:

1. “Chief Executive Officer” or “CEO” means the individual serving as the executive director of a Health Carrier.
2. “Health Benefit Plan” means a policy, contract, certificate or agreement offered or issued by a Health Carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
3. “Health Carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the State Insurance Regulator, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
4. “Medical and Surgical Services” means any services for medical conditions or surgical procedures, as defined under the terms of Health Benefit Plans, and in accordance with applicable Federal and State law, but does not include Mental Health or Substance Use Disorder Services.
5. “Mental Health and Substance Use Disorder Service” means any services for mental health conditions or substance use disorders, as defined under the terms of Health Benefit Plans, and in accordance with applicable Federal and State law.
6. “Prompt Pay Compliance Annual Report” means the report described in Section 6 herein.
7. “Prompt Pay Quarterly Report” means the report described in Section 4 herein.
8. “State Insurance Regulator” means the agency responsible for the licensing and oversight of Health Carriers.[[3]](#footnote-3)
9. “State Medicaid Agency” means the agency responsible for implementing the State’s Medicaid state plan agreement with the federal government and administering the State’s Medicaid and CHIP programs.
10. “State Office of the Attorney General” means the office of the chief legal officer of the State.
11. “State Prompt Pay Laws”[[4]](#footnote-4)

 **SECTION 4. TRANSPARENCY STANDARDS.**

1. PROMPT PAY QUARTERLY REPORTS. Health Carriers shall submit Prompt Pay Quarterly Reports, which include the information described herein in Section 5, not less frequently than quarterly to the State Insurance Regulator, in such form and manner and on such specific dates as the State Insurance Regulator may prescribe.
2. CERTIFICATION. The CEO of a Health Carrier shall certify, in such form and manner as the State Insurance Regulator may prescribe, the Prompt Pay Quarterly Report as containing true and correct information and acknowledging that it does not contain confidential or trade secret information.
3. PENALTY FOR LATE SUBMISSION. The State Insurance Regulator may establish fines of up to $500 per day for each day past the deadline for filing a Prompt Pay Quarterly Report.
4. MEDICAID. If Health Carriers are paid for services by the State Medicaid Agency or its designated agents, Health Carriers shall submit a duplicate copy of the Prompt Pay Quarterly Report to the State Medicaid Agency in such form and manner and on such specific dates as the State Insurance Regulator may prescribe.

**SECTION 5. REQUIRED SUBMISSIONS.**

1. COMPLIANCE METRICS. Health Carriers shall submit Prompt Pay Quarterly Reports as described herein in Section 4 which include the following information:
2. The percentage of claims the Health Carrier denied or rejected as a result of a provider not meeting the applicable clean claim definition;
3. The percentage of paid and denied clean claims;
4. The average number of days from receipt of claims meeting the applicable clean claim definition to payment of such claims;
5. The rates of compliance with State Prompt Pay Laws, which shall include the percentage of claims paid within the applicable State Prompt Pay Laws’ timeframes and the percentage of claims paid outside of the State Prompt Pay Laws’ timeframes;
6. For any claims not timely paid, the amount of interest due to providers, the amount of interest that had been paid to providers, and the fines, if any, imposed by the State Insurance Regulator under State Prompt Pay Laws; and
7. For any denied claims, the percentage of such denied claims that were appealed and the rate of the reversal of such denied claims upon appeal.
8. LINES OF BUSINESS. Health Carriers shall report on the above compliance metrics in the aggregate and for each line of business, as determined by the State Insurance Regulator.[[5]](#footnote-5)
9. MENTAL HEALTH PARITY. Health Carriers shall report on the compliance metrics for each of the following types of provider services:
	1. Medical and Surgical Services for each lines of business, as determined by the State Insurance Regulator;
	2. Mental Health and Substance Use Disorder Services for each line of business, as determined by the State Insurance Regulator.

**SECTION 6. ACCOUNTABILITY STANDARDS**.

1. PROMPT PAY COMPLIANCE ANNUAL REPORT. State Insurance Regulator shall publish and make available online, not less frequently than annually, a Prompt Pay Compliance Annual Report, detailing each Health Carrier’s compliance with the State Prompt Pay Laws and the status of any enforcement activities, including the amount of financial penalty, if any, imposed on a Health Carrier.
2. SUBMISSION TO LEGISLATIVE COMMITTEES. The State Insurance Regulator shall provide a copy of the Prompt Pay Compliance Annual Report to the state legislative committees with jurisdiction over the regulation of health insurance and the Medicaid agency.
3. SUBMISSION TO ATTORNEY GENERAL. The State Insurance Regulator shall send a duplicate copy of the Prompt Pay Compliance Annual Report to the state Office of Attorney General.

**SECTION 7. SEVERABILITY.**

If any provision of these Sections or the application thereof is held invalid, such invalidity shall not affect the provisions or applications of these Sections which can be given effect without the invalid provisions or applications.

**SECTION 8. EFFECTIVE DATE.**

This Act shall take effect in 60 days.

1. These general findings should be tailored by individual States to incorporate findings from any legislative hearings, executive branch reports, and news reports. [↑](#footnote-ref-1)
2. This finding will vary depending on whether a state has enacted prompt pay laws. [↑](#footnote-ref-2)
3. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a State should add language referencing that agency to ensure the appropriate coordination of responsibilities. [↑](#footnote-ref-3)
4. “State Prompt Pay Laws” should be defined by reference(s) to applicable State laws. [↑](#footnote-ref-4)
5. This model legislation allows the state insurance regulator to define the lines of business detailed in the compliance reports. For instance, the state insurance regulator could require insurers to separately report by Medicaid, Medicare, individual and group market products. [↑](#footnote-ref-5)