GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

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HOUSE BILL 1343
Second Edition Engrossed 5/31/05

Short Title:	Health Insur./Prompt Pay Correction.	(Public)
Sponsors:	Representative Nye.	
Referred to:	Health.	

April 21, 2005

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE PROMPT PAY STATUTE TO ALLOW PARTIES TO AGREE TO CERTAIN TERMS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-225 is amended by adding the following new subsection to read:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

…

"(n) The provisions of this section may not be amended by contract including the notification requirements under subsection (b) of this section, requirements to specify good faith reason or reasons for denial, processes for denying and reopening a claim, payment of interest as specifically described under subsection (e) of this section, requirements that insurers permit at least 180 days after the date of provision of care or patient discharge as described in subsection (f) of this section, provision of claim status reports under subsection (g) of this section. To the extent that insurers have contract provisions in existence or execute in the future specific provisions in provider contracts that are less favorable to providers than this section, those provisions shall be superseded by the more favorable provisions in this section, and health care providers shall be notified in writing by insurers within 30 days of the superseded provisions."

SECTION 1.1. G.S. 58-3-225(b) reads as rewritten:

"(b) An insurer shall, within ~~30~~ 15 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

(1) Payment of the claim.

(2) Notice of denial of the claim.

(3) Notice that the proof of loss is inadequate or incomplete.

(4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.

(5) Notice that coordination of benefits information is needed in order to pay the claim.

(6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all."

SECTION 2. G.S. 58-3-225(f) reads as rewritten:

"(f) Insurers may require that claims be submitted within 180 days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. However, except as otherwise provided in subsection (n) of this section, an insurer may not limit the time in which claims may be submitted to fewer than 180 days. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required."

SECTION 3. This act is effective when it becomes law and applies to contracts executed on and after that date.