

**State of Rhode Island and Providence Plantations
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
233 Richmond Street
Providence, RI 02903**

CONCISE EXPLANATORY STATEMENT

**REGULATION 7
PROMPT PROCESSING OF CLAIMS**

The Office of the Health Insurance Commissioner (“OHIC”) hereby adopts Regulation 7 as October 6, 2006, with an effective date of January 1, 2007, and makes this statement in accordance with R.I. Gen. Laws § 42-35-2.3. This regulation is adopted to effectuate administration and enforcement Rhode Island’s prompt processing statutes, set out at R.I. Gen. Laws §§ 27-18-61, 27-19-52, 27-20-47 and 27-41-64. This regulation will replace the state’s existing prompt processing regulation issued by the Department of Business Regulation in 2003.

The proposed regulation was made public on June 6, 2006 and a public hearing was held at 10 a.m. on July 25, 2006 in the Main Hearing Room of the Department of Business Regulation building, 233 Richmond Street, Providence, Rhode Island.

A number of written and oral comments were submitted before and during the public hearing. Changes were made to the proposed regulation as a result of the comments. The differences between the text of the proposed regulation and the regulation as adopted are as follows:

Section 3(b) – The OHIC has accepted the comment that the definition of “claim” be changed so as to make clear that claims under the Medicare Advantage and Medicare Prescription Drug Plans are exempted from this regulation.

Sections 3(f) and 3(o) – The OHIC has accepted the comment that the definition of “pay” or “paying” or “paid” should be amended to make clear that a claim can be processed and paid by crediting the amount of the claim toward a deductible. In addition, such a claim will be considered paid on the date of final adjudicated.

Section 3(h) – The OHIC has accepted the comment that the definition of “deny” or “denying” or “denied” or “denial” should be changed to included claims denied for any reason. The definition in the proposed regulation had been based on the definition in DBR Regulation 102 and had been limited to denials where the claim was not for a covered service or where the claim was rendered to a person other than a policyholder. The commenter correctly points that a claim can be denied for many reasons beyond those listed in the proposed regulation.

Section 3(n) – The OHIC has accepted the comment that the definition of “operating in this state” should be changed to make clear that it covers carriers offering health

insurance pursuant to chapter 18 of title 27 of the Rhode Island General Laws. Although the OHIC believes that the proposed regulation makes clear that such carriers are covered by the regulation, the definition of “operating in this state” was amended to remove any question as to whether such carriers are covered by this regulation.

Section 3(p) – The OHIC has accepted the comment that the definition of “pend” or “pending” or “pended” should be amended to remove the language that suggests that a written notification must be sent to a provider as soon as a claim is pended. As the commenter pointed out, a claim may be pended for a period shorter than the processing timeframes required by this regulation (thirty days for an electronic claim and forty days for a written claim) before the claim is ultimately paid or denied. This change makes clear that if a claim is first pended and then either paid or denied within the processing timeframes, notice of the pending need not be sent to the provider.

Section 4, Example 6 – The OHIC has accepted the comment questioning the relevance of the in-network/out-of-network status of a provider for the purposes of applying the processing requirements of this regulation to out-of-state insurers that operate plans in Rhode Island. A “plain language” construction of the prompt processing statutes suggests that no such distinction was intended by the General Assembly. An entity that operates a health plan in Rhode Island is subject to the requirements of the prompt processing statutes and this regulation. Therefore, any claims submitted to that entity by a Rhode Island, non-institutional provider will be subject to the processing timeframes required by this regulation. In addition, the reports submitted by the out-of-state insurers that operate plans in Rhode Island must include processing information for all Rhode Island claims.

Sections 6(b) and 7(e) – The OHIC has accepted the comment that documents submitted for a finding of substantial compliance under Section 6 and for reporting requirements under Section 7 will be considered public records under Rhode Island General Laws § 38-2-1 *et seq.*, but only to the extent that such documents do not contain personal, identifiable health information.

Exhibit B – The OHIC has accepted the comment that the report should reflect claims processing data (claims that are paid, pended or denied) and not just data for claims paid. The report has been expanded to include fields for such data.

Additional comments were made for which the OHIC has declined to make the suggested changes. Those sections are:

Sections 3(j) – The OHIC has declined to make a change to the definition of “Health care provider.” A commenter has suggested that the OHIC’s definition in Section 3(j) is too narrow and inconsistent with the prompt processing statutes because the Section 3(j) definition only pertains to Rhode Island providers. The OHIC believes that the intent of the General Assembly in enacting the prompt processing legislation was to protect Rhode Island’s individual health care providers. The OHIC has promulgated this regulation to effectuate that purpose.

Section 4, Examples 8 and 9 – The OHIC has declined to make a change to these examples. In addition, the OHIC has declined to exclude self insured entities from this regulation. No such exclusion is present in the prompt processing statutes. Furthermore,

the OHIC does not believe that the requirements imposed by the prompt processing statutes and this regulation are preempted by federal law.

Sections 10 – The OHIC has declined to make a change to Section 10. Various sections of chapters 18, 19, 20 and 41 of titles 27 and 42 of the R.I. Gen. Laws, including §§ 42-14-16, § 42-14-16.1, 27-18-3.3, 27-18-20, 27-18-46, 27-19-39, 27-20-33, 27-41-19, 27-41-21 and 27-41-47, expressly provide for the imposition of penalties for a violation of the provisions of chapters 18, 19, 20 and 41, including the prompt processing provisions of those chapters. Section 10 makes clear that the penalty provisions of chapters 18, 19, 20 and 41 will be enforced. Accordingly, Section 10 is not broad or vague. Furthermore, the OHIC believes that the phrase “A failure to comply with any of the requirements of this regulation may result in the imposition of any or all administrative penalties authorized by chapters 27 and 42 of the R.I. Gen. Laws” is sufficiently clear to put subject entities on notice that *any* violation of this regulation could result in the imposition of an administrative penalty.

Sections 12 – The OHIC has declined to make a change to Section 12. A number of commentators raised the issue of whether the Section 12 should be included in the regulation. A private cause of action for any violation of the provisions of chapters 18, 19, 20 and 41 of title 27 of the General laws is expressly authorized in each of those chapters. See, e.g., R.I. Gen. Laws § 27-18-47(a) (“A physician or other medical provider who alleges a violation of this act may bring a civil action for appropriate injunctive relief, actual and punitive damages and costs including reasonable attorney fees.”). See also R.I. Gen. Laws §§ 27-19-39, 27-20-34 and 27-41-48. Thus, Section 12 is consistent with the General Laws and is appropriately included in this regulation.

Examples – The OHIC has declined to move the examples included in the regulation to an appendix or other attachment. The OHIC believes that such a change is not only unnecessary, but would also limit the effectiveness of the examples.

Exhibit C – The OHIC has declined to incorporate portions of the Ohio Department of Insurance’s provider complaint form into Exhibit C. Exhibit C is designed solely to address provider complaints related to the timeliness of claims processing, whereas the Ohio provider complaint form covers a wider range of provider complaints. In addition, Exhibit C was designed with input from the state’s two largest health insurers. When properly completed, Exhibit C will contain all the information health insurers need to track the disputed claim(s.)