**§ 7703. Prompt Payment.**

(a) Within 180 calendar days of the effective date of this Act, for covered services rendered to its members, a health insurance issuer shall reimburse any person entitled to reimbursement under the health plan within forty (40) calendar days after the date of receipt on a clean claim.

(b) If a health insurance issuer fails to comply with subsection (a), the health insurance issuer shall pay interest beginning on the forty-first (41st) calendar day after the receipt of the claim if the date of payment is not within forty (40) calendar days. A formal claim by the person filing the original claim shall not be required.

(c) For electronic claims, the interest payable shall be at a monthly rate from the receipt of claim of:

(1) One and one-half (1.5) percent from the 41st day through the 60th calendar day;

(2) Two (2) percent from the 61st day through the 120th calendar day; and

(3) Two and one-half (2.5) percent after the 120th calendar day.

(d) For paper claims, the interest payable shall be at a monthly rate of:

(1) Two and one-half (2.5) percent from the 41st day through the 60th calendar day;

(2) Three (3) percent from the 61st day through the 120th calendar day; and

(3) Three and one-half (3.5) percent after the 120th calendar day.

(e) This section shall not apply to claims if the Health Insurance Issuer:

(1) Notifies the person submitting the claim within 30 calendar days after the receipt of the claim that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute;

(2) States, in writing, to the person the specific reasons why the legitimacy of the claim, a portion of the claim, or the appropriate amount of reimbursement is in dispute; and

(3) Pays any undisputed portion of the claim within 40 calendar days of the receipt of the claim.

(f) The Health Insurance Issuer shall process the disputed portion of the claim within 40 calendar days after receipt of all reasonable and necessary documentation.

(g) If a Health Insurance Issuer fails to comply with the requirements of subsection (f), it shall pay interest at the rates set forth in subsections (c) and (d) beginning on the 41st calendar day after the filing of the receipt of the documentation as provided in subsection (f).

(h) A Health Insurance Issuer shall allow a provider a minimum of 180 calendar days from the date a covered service is rendered or the date of inpatient discharge to submit a claim for reimbursement for the service.

(i) There shall be a rebuttable presumption that a claim has been received by a Health Insurance Issuer:

(1) Within 15 business days from the date the provider or person entitled to reimbursement placed the claim in the United States mail;

(2) Within 8 working hours if the claim was submitted by the provider or provider's agent electronically and was not returned to the provider by a health care clearinghouse or returned to the provider by the insurer if submitted directly to the health insurer; or

(3) On the date recorded by the courier if the claim was delivered by courier.

(j) Each Health Insurance Issuer shall provide a manual or other document that sets forth the claims submission procedures to all contracting providers at the time of contracting and 30 calendar days prior to any changes in the procedure.

(k) A Health Insurance Issuer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including electronic or facsimile confirmation of receipt of a claim.

(l) A Health Insurance Issuer shall not be in violation of this chapter if its failure to pay a claim in accordance with the time periods provided in this chapter is caused:

(1) In material part by the person submitting the claim; or

(2) By impossibility due to matters beyond the health insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages.

(m) This section shall not apply to claims for which payment has been or will be made directly to Health Care Providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the health insurer's obligation on such claims.

(n) Nothing in this chapter shall prevent a Health Care Provider and Health Insurance Issuer from entering into a services agreement with a stricter time frame for payment and/or penalty schedule.

**Source:** PL 20-88 § 2(103) (Feb. 8, 2019), modified.

**Commission Comment:** In codifying PL 20-88, the Commission numbered the sections pursuant to 1 CMC § 3806(a). The Commission struck "of this section" in (b) and (g) and capitalization of defined terms in (e)–(n) pursuant to 1 CMC § 3806(f).