
OLR Bill Analysis

SB 341

AN ACT CONCERNING RETURN OF HEALTH CARE PROVIDER PAYMENTS.

SUMMARY

This bill makes various changes to laws on claim payments and appeals between contracting health organizations (managed care organizations and preferred provider networks) and health care providers (for example, physicians).

Specifically, the bill:

1. reduces, from 18 months to 12 months, the time period after receiving a clean (complete and error-free) claim by which a contracting health organization may generally cancel, deny, or demand full or partial return of payment from a health care provider for an administrative or eligibility error;
2. specifies that for the existing requirement to give providers 30 days minimum advance notice of a payment cancellation, denial, or demand, notice must be sent (a) by certified mail, return receipt requested, if sent by mail or (b) to an email address the provider designates, if sent by email; and
3. requires the organization to notify the provider of its appeal determination within 15 business days after receiving the provider's appeal, or else the appeal must be construed in the provider's favor.

EFFECTIVE DATE: January 1, 2027

PAYMENT CANCELLATION, DENIAL, OR RETURN

Time Limit

Current law generally prohibits a contracting health organization from canceling, denying, or demanding the return of full or partial payment for an authorized covered service due to administrative or eligibility error, more than 18 months after receiving the claim. The bill reduces this to 12 months after receiving the clean claim.

Under existing law, unchanged by the bill, the time limit does not apply if the:

1. organization (a) has a documented basis to believe that the provider fraudulently submitted the claim, (b) already paid the provider for the claim, or (c) paid a claim that should have been or was paid by a federal or state program; or
2. provider (a) did not bill the claim appropriately based on documentation or evidence of what medical service was provided or (b) received payment from a different insurer, payor, or administrator through coordination of benefits, subrogation, or coverage under an automobile insurance or workers' compensation policy.

Advance Notice

Under existing law, an organization must give a provider at least 30 days' advance notice of a payment cancellation, denial, or return demand by mail, e-mail, or fax. The bill specifies that if the notice is sent by mail, it must be sent by certified mail, return receipt requested; and if it is sent by email, it must be sent to the provider's designated email.

Appeal

By law, a provider may appeal, following the organization's procedures, a payment cancellation, denial, or return demand within 30 days after receiving notice of it. The bill requires the organization to notify the provider of the appeal determination within 15 days after receiving the appeal. Under the bill, if the organization fails to do so, then the appeal must be construed in the provider's favor.

Existing law, unchanged by the bill, requires a payment return demand to be stayed (postponed) during the appeal.

BACKGROUND

Related Bill

sHB 5377, favorably reported by the Insurance and Real Estate Committee, has similar provisions. It (1) reduces the period to cancel, deny, or demand payment on a clean claim from 18 months to 15 months; (2) has an identical provision on the mail and email requirements; and (3) requires the organization to communicate its appeal determination to the provider within 12 days of receiving the appeal.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable

Yea 13 Nay 0 (03/12/2026)