WEST VIRGINIA LEGISLATURE

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Introduced

House Bill 4614

FISCAL NOTE

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[Introduced February 18, 2016; Referred
to the Committee on Banking and Insurance then
Health and Human Resources.]

A BILL to amend and reenact §33-45-2 of the Code of West Virginia, 1931, as amended, relating to providing the medical loss ratio contained in any Medicaid managed care contract applicable to any Medicaid managed care organization may not be less than ninety percent.

Be it enacted by the Legislature of West Virginia:

That §33-45-2 of the Code of West Virginia, 1931, as amended, be amended and reenacted to read as follows:

ARTICLE 45. ETHICS AND FAIRNESS IN INSURER BUSINESS PRACTICES.

§33-45-2. Minimum fair business standards contract provisions required; processing and payment of health care services; provider claims; required medical loss ratio threshold; commissioners jurisdiction.

(a) Every provider contract entered into, amended, extended or renewed by an insurer on or after August 1, 2001, shall contain specific provisions which shall require the insurer to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

(1) An insurer shall either pay or deny a clean claim within forty days of receipt of the claim if submitted manually and within thirty days of receipt of the claim if submitted electronically, except in the following circumstances:

(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(2) Each insurer 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 relevant evidence as proof of the fact of receipt of the claim. If

an insurer fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by the person submitting the claim.

(3) An insurer shall, within thirty days after receipt of a claim, request electronically or in writing from the person submitting the claim any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. The insurer shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within fifteen days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested under this subsection which the insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, an insurer shall either pay or deny the claim within thirty days. No insurer may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the insurer fails to timely notify the person submitting the claim within thirty days of receipt of the claim of the additional information requested unless such failure was caused in material part by the person submitting the claims: *Provided,* That nothing herein shall preclude such an insurer from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision (7), subsection (a) of this section. This subsection does not require an insurer to pay a claim that is not a clean claim except as provided herein.

(4) Interest, at a rate of ten percent per annum, accruing after the forty-day period provided in subdivision (1), subsection (a) of this section owing or accruing on any claim under any provider contract or under any applicable law, shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is

paid or within thirty days thereafter.

(5) Every insurer shall establish and implement reasonable policies to permit any provider with which there is a provider contract:

(A) To promptly confirm in advance during normal business hours by a process agreed to between the parties whether the health care services to be provided are a covered benefit; and

(B) To determine the insurer's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for:

(i) Precertification or authorization of coverage decisions;

(ii) Retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim;

(iii) Provider-specific payment and reimbursement methodology; and

(iv) Other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim.

(C) Every insurer shall make available to the provider within twenty business days of receipt of a request, reasonable access either electronically or otherwise, to all the policies that are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the insurer may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

(6) Every insurer shall pay a clean claim if the insurer has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

(A) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

(B) The insurer's refusal is because:

(i) Another payor or party is responsible for the payment;

(ii) The provider has already been paid for the health care services identified on the claim;

(iii) The claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the insurer by the provider, enrollee, or other person not related to the insurer;

(iv) The person receiving the health care services was not eligible to receive them on the date of service and the insurer did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;

(v) There is a dispute regarding the amount of charges submitted; or

(vi) The service provided was not a covered benefit and the insurer did not know, and with the exercise of reasonable care could not have known, at the time of the certification that the service was not covered.

(7) A previously paid claim may be retroactively denied only in accordance with this subdivision.

(A) No insurance company may retroactively deny a previously paid claim unless:

(i) The claim was submitted fraudulently;

(ii) The claim contained material misrepresentations;

(iii) The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by the provider;

(iv) The provider was not entitled to reimbursement;

(v) The service provided was not covered by the health benefit plan; or

(vi) The insured was not eligible for reimbursement.

(B) A provider to whom a previously paid claim has been denied by a health plan in accordance with this section shall, upon receipt of notice of retroactive denial by the plan, notify the health plan within forty days of the provider’s intent to pay or demand written explanation of

the reasons for the denial.

(i) Upon receipt of explanation for retroactive denial, the provider shall reimburse the plan within thirty days for allowing an offset against future payments or provide written notice of dispute.

(ii) Disputes shall be resolved between the parties within thirty days of receipt of notice of dispute. The parties may agree to a process to resolve the disputes in a provider contract.

(iii) Upon resolution of dispute, the provider shall pay any amount due or provide written authorization for an offset against future payments.

(C) A health plan may retroactively deny a claim only for the reasons set forth in subparagraphs (iii), (iv), (v) and (vi), paragraph (A) of this subdivision (7) for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth in subparagraphs (i) and (ii) above.

(8) No provider contract may fail to include or attach at the time it is presented to the provider for execution:

(A) The fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis; and

(B) All material addenda, schedules and exhibits thereto applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

(9) No amendment to any provider contract or to any addenda, schedule or exhibit, or new addenda, schedule, exhibit, applicable to the provider to the extent that any of them involve payment or delivery of care by the provider, or to the range of health care services reasonably expected to be delivered by that type of provider, is effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment, or of the proposed new addenda, schedule or exhibit, and has failed to notify the insurer within twenty business days of receipt of the documentation of the provider's intention to terminate the provider contract at the

earliest date thereafter permitted under the provider contract.

(10) In the event that the insurer's provision of a policy required to be provided under subdivision (8) or (9) of this subsection would violate any applicable copyright law, the insurer may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

(11) The insurer shall complete a credential check of any new provider and accept or reject the provider within four months following the submission of the providers completed application*: Provided,* That time frame may be extended for an additional three months because of delays in primary source verification. The insurer shall make available to providers a list of all information required to be included in the application. A provider who is permitted by the insurer to provide services and who provides services during the credentialing period shall be paid for the services if the providers application is approved.

(b) Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every insurer subject to regulation by this article shall adhere to and comply with the minimum fair business standards required under subsection (a) of this section. The commissioner has jurisdiction to determine if an insurer has violated the standards set forth in subsection (a) of this section by failing to include the requisite provisions in its provider contracts. The commissioner has jurisdiction to determine if the insurer has failed to implement the minimum fair business standards set out in subdivisions (1) and (2), subsection (a) of this section in the performance of its provider contracts.

(c) Notwithstanding any provision of law to the contrary, the medical loss ratio threshold prescribed in any Medicaid managed care contract applicable to any Medicaid managed care organization may not be less than ninety percent.

~~(c)~~ (d) No insurer is in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the insurer's compliance is

rendered impossible due to matters beyond the insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages, which are not caused in material part by the insurer.

NOTE: The purpose of this bill is to provide the medical loss ratio in any Medicaid managed care contract applicable to any Medicaid managed care organization may not be less than ninety percent.

Strike-throughs indicate language that would be stricken from a heading or the present law, and underscoring indicates new language that would be added.